REPUBLIC OF ALBANIA
MINISTRY OF HEALTH

THE POLICY AND THE OPERATIONAL PLAN FOR MENTAL HEALTH SERVICES DEVELOPMENT IN ALBANIA

THE NATIONAL STEERING COMMITTEE FOR MENTAL HEALTH

"This document has been financed by the Swedish International Development Cooperation Agency, Sida, Sida does not necessarily share the views expressed in this material. Responsibility for this content rests with the author."

This publication includes two documents of great importance for the reforming process and the development of the mental health services in Albania. "Policy for Mental Health Services Development in Albania" approved by the Minister of Health in March 2003 and "Operational Plan for Mental Health Services Development in Albania" approved by the Minister of Health in May 2005. Each of the documents is accompanied by the respective official order issued by the Minister of Health for its approval and also by the content overview.

POLICY FOR MENTAL HEALTH SERVICES DEVELOPMENT IN ALBANIA

REPUBLIC OF ALBANIA
MINISTRY OF HEALTH
/Directory of Primary Health Care/
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Nr. 1034 Prot. **26.03.2003**

ORDER

Nr. 116, Date 25.03.2003

In support to the Mental Health reform that is among the priorities of the Albanian Health System,

I ORDER:

1. The approval of the Policy Document for Mental Health in Albania.

2. The Directory of the Primary Health Care, the Directory of the Hospital Care, the Directory of Economics and the University Hospital Center of Tirana, are requested to implement this Order.

3. This Order enters into power with immediate effect.

THE MINISTER

Mustafa XHANI

Signed and sealed

The original copy of the order of Minister of Health is found in page 4 of the Albanian section of this document.

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Ministry of Health of Albania

THE NATIONAL STEERING COMMITTEE FOR MENTAL HEALTH

Aware of the very dramatic conditions of the Psychiatric Services in Albania[1] and within the frame of the need for urgent action to improve the situation, Mental Health (MH) has been declared a priority of the development of Albanian Health System.

Within the Ministry of Health (MoH) Policy for improving Health Services to its population, the National Steering Committee for Mental Health (NSC - see the attached foundation form) was appointed by the Minister of Health by 11th May 2000, with the protocol number 248 with the mandate of:

1. Developing a Mental Health Policy
2. Planning for the Reform of Psychiatric Services
3. Following up, supporting and coordinating the implementation of innovative activities, experiences and services aimed to develop Community Based Mental Health Services (CMHS) and to promote and implement de-institutionalisation processes; and
4. Monitoring of such processes.

The World Health Organization (WHO), through the financial support of the Swedish International Development Agency, is supporting the whole action in collaboration with an International Network of WHO Collaborating Centers (Birmingham Northern Trust, University of Central England, Department of Health of England, Verona, Asturias), other United Nations Organizations (UNOPS), NGOs (Geneva Initiative for Psychiatry). These are centres and organizations with years of expertise on supporting and promoting De-institutionalisation reform processes and community based services, locally and within the frame of International Cooperation. They provide human and material resources to support the NSC and MoH, under the coordination of WHO.

The following is a MH Policy Document produced by the NSC with the support of WHO. It contains the main guidelines and recommendations that the process of reform is to follow, priorities, objectives and key fields to be reformed.

It has been elaborated taking into consideration:

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[1] See pg. 9, " Current situation of Albanian Mental Health Services"

- The current situation of Psychiatric services in Albania,
- The WHO recommendations to improve MH, World Health Report, 2001,
- The local social-economical-cultural context
- The local infrastructure
- The local available-sustainable resources
- The external short and medium-term resources (International funding)

This document will be followed by a detailed Implementation Strategy with defined realistic, sustainable activities and objectives, timetable, quality monitoring systems and outputs (within six months after the approval of this document)

This document is submitted to the Ministry of Health, as per its request and for its evaluation and eventual approval and submission to the appropriate authorities.

The recommendations contained in this document will become mandate of the Ministry of Health's concrete commitment for implementation through administrative instructions, and will be supported by the above mentioned Implementation Strategy Documents and International Agencies and Donors.

The agreement to this document is to be guaranteed by the implementation of the following priorities:

1. To secure continuous concrete commitment of all actors to deliver better services, closer to the community needs, fighting segregation and social exclusion, in the respect of human rights.

2. To create a Department for Mental Health Development within the Ministry of Health.

3. De-institutionalisation process, crucial to effectively secure cost efficiency in the long term. To be performed successfully it requires an initial injection of capital investment resources, technical and material, internal and external.

4. To establish a non Admission Policy for long term purposes (partial and gradual).

5. To overcome bureaucratic administrative constrains, by creating, defining and approving innovative strategies to rationalise the use of resources. Services should answer to communities' needs and not to their own institutional needs.

6. To officially include into the district public health structures the currently existing mental health services (demonstration projects) that were requested by the MoH and were technically and financially supported from international sources.

7. To officially launch community based demonstration systems.

8. To individuate sustainable, already existing, locally available resources (from Psychiatric Hospitals, wards and ambulatory services as well as from PHC and other branches) avoiding the raise of the Health Budget.

9. To define and institute a separated MH Budget, that includes all mental health services.

10. To integrate the mental health services within PHC.

11. To provide continuous training and extension of experience.

12. To review the Legal frame to guarantee the necessary tools to authorities, professionals, NGOs, mentally ill people, their families and the community at large, to access the right to treatment, housing, education, employment, etc.

13. To be sustainable and realistic, this process necessarily involves concretely both National and International actors with different levels of defined responsibilities. These responsibilities are to be declared, coordinated, coherent with the policies and plans developed by this Committee and in the maximum respect of users' rights to access equal, continuous, comprehensive and quality MH care services' and support.

14. To include this Document into the National Health Strategy.

1. INTRODUCTION TO MENTAL HEALTH[2]

Mental health has been defined variously by scholars from different cultures.

Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others.

From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively.

It is, however, generally agreed that mental health is broader than a lack of mental disorders. Mental and behavioural disorders are common, affecting more than 25% of all people at some time during their lives. They are also universal, affecting people of all countries and societies, individuals at all ages, women and men, the rich and the poor, from urban and rural environments.

They have an economic impact on societies and on the quality of life of individuals and families.

Mental and behavioural disorders are present at any point in time in about 10% of the adult population.

Around 20% of all patients seen by primary health care professionals have one or more mental disorders.

Mental and behavioural disorders are common, affecting more than 25% of all people at some time during their lives

One in four families is likely to have at least one member with a behavioural or mental disorder. These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination.

[2] From the World Health Report 2001

… Four of the ten leading causes of disability worldwide are neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease.

Estimation of the global burden of the disease with disability adjusted life years (DALYs) shows that mental and neurological conditions are among the most important contributors. The number of people with mental and neurological disorders will grow - with the burden rising to 15% of DALY lost by the year 2020, while in 1999 they accounted for 11% of the DALYs lost due to all diseases and injuries.

Groups at higher risk of developing mental disorders include people with serious or chronic physical illnesses, children and adolescents whose upbringing has been disrupted, people living in poverty or in difficult conditions, the unemployed, female victims of violence and abuse, and neglected elderly persons.

… four of the ten leading causes of disability worldwide are neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease.

2. AN ASSESSMENT OF THE CURRENT SITUATION OF THE ALBANIAN MENTAL HEALTH SERVICES

2.1. THE PSYCHIATRIC SERVICES AND THEIR ORGANISATION

The psychiatric services are organised within the Primary Health care level (Tirana only with its three ambulatory psychiatric units), the secondary level and the tertiary level.

Both the psychiatric hospitals in Elbasan and Vlora are the most autonomous in terms of using their own resources.

Psychiatric care in Albania has traditionally been delivered by centralised, biologically oriented, symptom-focused services. Primary Health Care is not yet recognised as a part of the psychiatric referral and/or treatment system.

Being that the services are concentrated into four districts of the country, where the psychiatric wards and hospitals are situated (Tirana, Elbasan, Vlora and Shkodra), they are hardly reachable by most of the population considering also the poor ambulatory services, thus suggesting a very poor referral system.

Being that the services are concentrated into four districts of the country, where the psychiatric wards and hospitals are situated, they are hardly reachable by most of the population

a) The in-bed facilities are represented by two psychiatric hospitals (Elbasan and Vlora) and two psychiatric wards (Tirana and Shkodra) within Polyvalent Hospitals. Except the differences on the administrative modalities of budget use, there is no other difference in the approach, in service provision or any other issue that could make the psychiatric hospitals and wards different from each other. The hospitals and wards have a total of 840 beds for in-patient services. This would not be a very low figure related to the population (3.100.000 inhabitants), but considering the fact that half of the beds are used for the long-term residents in the psychiatric hospitals (thus no bed turnover), this is hardly compatible with the presumed need for in-bed services in the country.

b) The out-patient facilities are represented by the so-called neuro-psychiatric cabinets, not available in each district, very often covering both needs for psychiatric and neurologic consultation. The cabinets are composed of one doctor and one nurse only that provide diagnostic, drug prescription, and referral to the invalidity pension commission and to the hospital for eventual admission. The doctors sometime are neurologists with poor knowledge of psychiatry. There are however, several of them that have received the course of neurology and psychiatry and are officially recognised as neuropsychiatrists. The nurses of those cabinets have never received any formal training in psychiatry, as there is no such training for nurses in the country.

   The long-term residents of the psychiatric hospital occupy almost half of the beds. There are speculations by the hospital staff themselves that most of them are staying in the hospitals due to lack of alternative shelter and it is our opinion that all of them are staying there due to lack of alternative community services.

c) Mental Health services for children and adolescents are concentrated in Tirana only and give answer to the needs of only 1% of children with mental health problems.

   The Child Development Center and the National Center for Child's Development, Well growth and Rehabilitation, offer some of the services needed, while one of the Polyclinics of Tirana, it has the Ambulatory Service for Children and Adolescents Psychiatry.

   The hospital structures are represented by the Psychiatric Clinic for Children and adolescents that is part of the Department of Psychiatry of the Tirana University Hospital Center. The number of psychiatric beds for children and adolescents is 0.3 per 100 000 inhabitants, being a number far from average European standards (including Eastern Europe - 2-3 per 100 000 inhab.); that is the lowest number in Europe with regard to the Children and Adolescents Services.

   There is not yet in Albania any post-graduate training programme for Children and Adolescents' Psychiatry.

The long-term residents of the psychiatric hospital occupy almost half of the beds and most of them are staying in the hospitals due to lack of alternative shelter.

2.2. THE HUMAN RESOURCES IN THE FUNCTION OF THE PSYCHIATRIC SERVICES

The figures of the human resources can hardly be identified, due to the confusion that still exists among the health authorities on differences between neurologists and psychiatrists

a) It is speculated, however, that one psychiatrist for every 78.000 inhabitants is available. The actual figure is even lower, considering the extreme centralisation of psychiatrists in the above mentioned four districts.

b) There are no more than two hundred nurses that work in psychiatric settings (including hospital and ambulatory ones). The actual figure is even lower, considering the fact that many of them in the psychiatric hospitals are not directly working with the patients, but involved in administrative and laboratory activities.

c) The human resources in the hospitals also involve the so-called caretakers, that are usually not-qualified workers supposed to assist the admitted patients in their every day needs. Often they work as nurses (especially during night shifts) due to lack of nurses or even worse, due to neglect and abusive agreements between hospital's staff.

d) Social Workers and Psychologists did not exist in the Psychiatric Services until recently. Due to the reforming changes of the health system in general, psychologists and social workers have recently been on the public payroll of the national health services.

Several newly educated psychiatrists are still unemployed by the public structures, or do not prefer to go back and work as psychiatrists in their districts of origin.

There is a difference in resources between Tirana psychiatric ward and the rest of the facilities. Due to the fact that this is a university hospital setting, many human resources are sharing the time between teaching and clinical work, thus in Tirana there is a higher rate of human resources related to number of beds.

2.3. TRAINING AND EDUCATION IN PSYCHIATRY

a) The medical education for future physicians (a six years course) includes a three week internship in the Psychiatric ward of the Tirana University Hospital Center.

b) The residency for psychiatrists lasts four years. This is a regulation made and applied by the Faculty of Medicine during the last decade. The majority of the psychiatrists working in the hospitals have received the one-year residency course of the period before. The last decade has been a flourishing one consisting of a considerable increase of residents in psychiatry. Several of them are still unemployed by the public structures, or do not prefer to go back and work as psychiatrists in their districts of origin.

c) The two year residency training for Family Doctors includes only a two week training in Psychiatry.

The three training courses described above are effectuated in the University Hospital Center of Tirana only. There is no possibility to receive such training courses in other districts or facilities of the country.

d) There is no special training or education course for psychiatric nursing.

2.4. ECONOMICS AND MANAGEMENT OF PSYCHIATRIC SERVICES

The evaluation of psychiatric inpatient cost has been focused on the cost evaluation of the two State Mental Health Hospitals in Elbasan and Vlora and also of the two psychiatric wards in Tirana and Shkodra. As has been mentioned above, the hospital of Elbasan (400 beds) and the hospital of Vlora (280 beds) are two health institutions that are founded independently with a specific annual budget based on the accountability of the previous year. On the other hand, the psychiatric services of Tirana (120 beds) and of Shkodra (110 beds), being part of two polyvalent institutions (Tirana University Hospital Center and the General Hospital of Shkodra) do not have an independent accountability and are administered as parts of these wider institutions.

....the differences in running cost components, reflect the lack of a common policy regarding the administration of inpatients psychiatric services.

Usually the distribution of expenditure reflects the number of beds in each service. Even though, the differences in running cost components, as showed in the table below, reflect the lack of a common policy regarding the administration of inpatients psychiatric services.

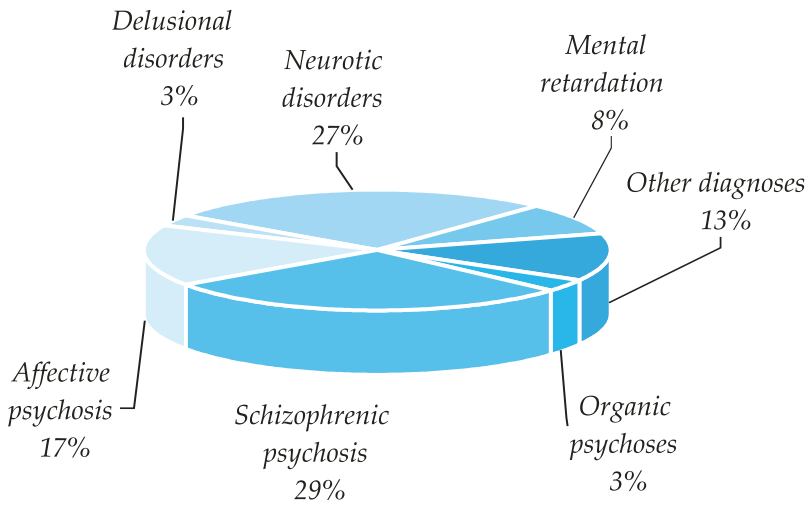
	Elbasan		Vlora		Tirana		Shkodër	
Cost component	Lek	%	Lek	%	Lek	%	Lek	%
Personnel	760	51	378	42	1458	47	650	47
Running costs	732	49	519	58	1675	53	747	53
Water, Electricity, Heating	94	6	26	3	145	5	65	5
Cleaning, Laundry, Catering	116	8	62	7	230	7	102	7
Equipment Maintenance	165	11	61	7	279	9	125	9
Food	254	17	267	30	733	23	327	23
Drugs	39	3	51	6	129	4	58	4
Transports	7	0	9	1	23	1	10	1
Other running costs	34	2	39	4	103	3	46	3
Administrative costs	22	1	6	1	33	1	15	1
Total costs per day	1492	100	897	100	3133	100	1397	100

It can be noticed that the cost differences between the above institutions are rather significant, even though the quality of the services provided by each of them is quite similar.

The following figure reports the distribution of admission in Albania during 1999 by diagnosis (ICD-9) as centrally reported to the Ministry of Health.

Many international studies clearly showed, as summarised by Goldberg (1991)[4] , that a hospital based approach is less effective, as well as less cost-effective, compared to community-based care and only has the effect of developing chronic course of the illness.

[4] Goldberg D. (1991). Cost-effectiveness studies in the treatment of schizophrenia: a review. Schizophrenia Bulletin 17, 3, 453-459



In 2000, State Mental Hospitals admitted 952 patients, more than half of them coming from other districts. The mean length of stay (LoS) was 165.5 days (124.8 in Elbasan and 212.9 in Vlora). The occupancy rate was very low (63.5%), revealing that the allocation of resources is far from cost-effective.

Costs per day of admission range from about 7 USD (Vlora) to 23 USD in Tirana; personnel costs are about 50% of the total cost, and food costs rank second in both hospitals evaluated.

Costs per day of admission are very low if compared to other European Countries. The differences in costs between Albanian admissions and other European Countries reflects the poor conditions of the wards and hospitals and the quality of care provided.

Policy makers have to set up a funding system better tailored to community-based psychiatric services. The actual funding system of mental hospitals in Albania is based on post reimbursement of all expenditures as they are declared. This procedure induces a lack in quality of care provided and many Countries moved towards prospective funding systems. Fee for services and prospective payments (such as capitation systems or services' budget) have been demonstrated to be more effective in producing improvements.

2.5. THE SOCIAL MENTAL HEALTH ORIENTED SERVICES

There is no real network of comprehensive social services in Albania. The new initiatives taken by the Albanian government and supported and implemented by local and international organizations are not foreseeing any space for the mentally ill as clients/users of social services. That means that, in the near future, a better collaboration with the responsible authorities is needed in order to involve the mentally ill in the target population of the social services.

The few services that are currently operating in Albania on the social needs for the mentally ill are not reliable on a long-term perspective because:

a) They are financially supported by external funding, thus offering poor sustainability.

b) They are almost exclusively set up in Tirana, thus hardly reachable by the rest of the country population.

2.6. THE SOCIAL/FAMILY TISSUE

Albania belongs to the countries where the community spirit is still high, thus encouraging the acceptance of the mentally ill. The Albanian family is well known for the acceptance of the weaker member within the family, the maintenance of a relationship and a responsibility with mentally ill during acute crisis hospitalisations and even after long lasting institutionalisation in many cases, and the relatively good integration of mentally ill in the small communities. All those are positive aspects already present in this community, mechanisms that we should accurately safeguard from excessive medicalisation of the answers. On the other hand, the involvement of the Albanian family in the care taking of the mentally ill overloads the family that lacks the necessary knowledge and resources, and may even prevent the social integration of the mentally ill by segregating and isolating them at home. Therefore, in some cases there is a neglect of care seeking and care receiving even there where

Policy makers have to set up a funding system better tailored to community-based psychiatric services

such help would be available. It is thus absolutely necessary to elaborate strategies that aim at avoiding the family burden and involve them in the services management as a resource.

There are very few, still weak, family or users' associations in Albania.

Summarizing, the family being the exclusive supporter to the mentally ill, itself needs support for two major reasons:

a) To alleviate the families' burden due to the mental illness of a relative.
b) To increase the families' skills and provide the appropriate attitudes in taking care of a mentally ill relative.

In financial terms, such action means a less expensive intervention with longer lasting effects.

...the family being the exclusive supporter to the mentally ill, itself needs support to alleviate the burden and to increase the skills in taking care of a mentally ill relative.

3. NATIONAL GOAL AND STRATEGIC KEY-POINTS TO REACH IT

ESTABLISHMENT AND DEVELOPMENT ON A NATIONAL LEVEL OF THE COMMUNITY MENTAL HEALTH CARE SYSTEM

The worldwide-recommended Community Based MH Services cannot be implemented in Albania without a reconversion of resources and approaches. The only safe way to reach cost-efficient community based mental health services accessible to all is deinstitutionalisation of Psychiatric Hospitals, wards and institutionalised answers in general.

Setting up a network of new services without taking this into consideration this would have a non-locally affordable cost and a huge risk to fail.

Every MH service should be able to cope with three main problems:

- Abandon of psychiatric patients,
- Inappropriate services (partial and weak answers, only psychotherapeutic, or only pharmacological)
- Segregative answers (Psychiatric Hospitals).

The only safe way to reach cost-efficient community based mental health services accessible to all is deinstitutionalisation of Psychiatric Hospitals, wards and institutionalised answers in general.

All these problems should to be faced at once: leaving one of them unsolved would prevent from solving the other two. Only a comprehensive answer can be built up around these three main problems.

De-institutionalisation means:

a) Prevention of inappropriate admissions in the psychiatric hospitals and establishment of community structures.
b) Dismissions from the psychiatric hospitals and integration into the community of the previously institutionalised patients with an adequate preliminary skills' training.
c) Establishment and strengthening of the supporting

community systems for the non-institutionalised patients.

De-institutionalization towards Community Mental Health implies:

a) Shifting of resources from Psychiatric Hospitals and Wards towards the Community.
b) Downsizing the psychiatric hospitals: hospital capacity is to be reduced gradually while community based structures are set up.
c) Admissions to chronic wards are to be gradually stopped.
d) Additional resources are to be shifted from PHC, other health branches as well as from other sectors (local governments, social services, etc).
e) Non medical and non technical resources are crucial and mechanisms to include them in the system (vocational therapists or partnerships with social enterprises, for example) are to be individuated.

3.1. DOWNSIZING HOSPITALS

A gradual downsizing of the hospital setting is then crucial in the de-institutionalisation process.

The gradual downsizing of the hospital structure cannot happen without a reconverting of its resources, re-addressing them into community services. Considering that the new networks of community-based services will be able to prevent hospitalisations (by providing care at home and in day-centres, long-term care in protected structures, support to access job and other social networks and services, support to PHC, support to families, etc) the total number of beds currently existing in Albania can be considered high enough to initially cope with the needs for in-bed treatment. Crucial becomes instead the "re-distribution" of these beds considering demographic features and areas of care. As the process of reform proceeds, hospital beds are to be shifted (with all other resources allocated to them, like food, personnel, other maintenance costs, etc) into protected apartments, 24 hrs/ community - based centers, and small wards located/integrated into general hospitals, and emergency services. The modality is

The gradual downsizing of the hospital structure cannot happen without a reconverting of its resources, re-addressing them into community services.

to be chosen considering the local conditions that differ from Tirana to Elbasan, to Shkodra, to Dibra, etc. An example is given below, considering the situation at Tirana (see "A proposal to start", pg. 21).

Every community has its own standards, and these have a meaning strictly related to the local conditions and community features. The better the community resources are identified and utilised, the better the cost/effectiveness of the services to develop.

It is fair and desirable to assume that a new offer of services of improved quality will encourage many of those families and communities to seek support, causing the hidden demand to emerge.

This situation will conduce to:

i. Improved access to services for all population
ii. Improved mental health of the communities
iii. Early intervention and prevention
iv. Increased request of community services
v. Decreased hospitalisations as a consequence.

A national non-admission policy to chronic wards is to be gradually applied as community answers develop. Criterions for admissions should be defined taking into consideration specific indicators such as family situation, alternative services present in the users' residence area, age, etc.

a) A survey is to be conducted within hospitals (completing the one performed in Vlora Psychiatric Hospital and Shkodra Psychiatric ward by UNOPS/PASARP) to better understand what are the real resources contained, the real problems outstanding, the real needs, implementing at the same time coherent interventions tending to de-institutionalisation.
b) A review of the regulation of psychiatric hospitals, of their Terms of Reference, of the mechanisms of quality assurance, monitoring, etc is necessary.
c) Every Psychiatric hospital and ward should develop a master plan to redistribute its beds and other resources and shift

Community care means continuity and responsibility of care provided close to the living context, using the resources that the community offers

care into the community.

d) A working group on hospitals' de-institutionalisation (within NSC) should be instituted to perform and/or supervise such activities. This group should involve specific local and international expertise.

3.2. TERRITORIALIZATION / DECENTRALIZATION

Community care means to offer therapeutic relationships instead of only isolated therapeutic acts.

Community care means continuity and responsibility of care provided close to the living context, using the resources that the community offers, a comprehensive approach: multidisciplinary, participative and networked.

The responsibilities should be determined for defined geographic areas; they should be managed by Community Based Systems integrated into the PHC that will ensure the above stated approach elements.

Officially setting-up of Mental Health Departments, dependent to the Public Health Authority means:

a) Mental Health Departments, consisting of one director, one administrative assistant, a defined budget, defined ToR and responsibility over all the mental health structures (in-bed and outpatient) in a defined area.

b) Every Mental Health Department should become able to provide answers to all mental health needs (primary and secondary level) of its catchment area. This implies the elaboration of specific master plans with clear time-limited objectives for de-institutionalization (including hospital de-institutionalization master plans) and for community services development. The manager (director's) engagement is to be strictly related to the master plan and objectives targeted.

c) By re-defining the catchment areas, related responsibilities and modalities of cooperation between them, the short cuts of responsibility should be accurately addressed. This task is fundamental to keep the care as close to the belonging

By re-defining the catchment areas, related responsibilities and modalities of cooperation between them, the short cuts of responsibility should be accurately addressed.

community as possible, avoiding chronicity paths and institutionalization.

d) Mental health care should be provided by PHC and secondary level services in every catchment area, strengthening the process of decentralization of the answer. In this way, Tirana psychiatric ward professionals' will be released for better performing their academic and services' provision tasks.
e) Even if the academic responsibilities are to be kept in Tirana, modalities to get psychiatric training while working in distant areas should be individuated and implemented.

Departments of MH will have different organizational modalities according to the specificity of the area.

While in some places basic services can be offered by a small psychiatric ward integrated into the general hospital, a Community Based MH Day-Centre, protected structures for long term patients and rehabilitation settings, in others, beds for acute care can be placed in the community mental health centres with a 24 hour service.

The organisational modalities will depend on the local circumstances.

While in some places basic services can be offered by a small psychiatric ward integrated into the general hospital, a Community Based MH Day-Centre, protected structures for long term patients and rehabilitation settings, in others, beds for acute care can be placed in the community mental health centres with a 24 hour service.

4. THE COMMUNITY MENTAL HEALTH SYSTEM

Care in the community, as an approach means:

a) Services which are close to home, including General Hospital Care for acute admissions, and long-term residential facilities in the community;
b) Interventions related to disabilities as well as symptoms;
c) Treatment and care specific to the diagnosis and needs of each individual;
d) A wide range of services which addresses the needs of people with mental and behavioural disorders;
e) Services which are coordinated between mental health professionals and community agencies;
f) Ambulatory rather than static services, including those that can offer home treatment;
g) Partnership with carers and meeting their needs;
h) Legislation to support the above aspects of care.

Within this frame, the community mental health care follows the prevention policies promoted and embraced by the modern health care worldwide:

Primary prevention: seeks the prevention of the disease performance and consequently the decrease of its incidence.

Secondary prevention: seeks early detection and treatment of the disease and consequently the decrease of the prevalence.

Tertiary prevention: seeks the decrease of the residual disability due to the disease.

In order to ensure the above-mentioned functions and the efficacy of the preventive policies, the collaboration of the structures in the following levels is needed:

I) Collaboration within the mental health service, between its composing elements.

II) Collaboration within the health system, between mental health services and other services (primary and secondary care).
III) Collaboration between health services and other public services, including social services and housing departments.

4.1 THE POLITICAL LEVEL

So far is represented by the National Steering Committee, a multidisciplinary inter-ministerial body, bringing together representatives from the Ministries of Health, Education and Social Welfare, representatives of professional associations and Children and Adolescents' mental health. The Committee is aware of the importance of involvement of district representatives.

In addition, the Ministry of Health should appoint a small "Department for Mental Health Development" within the Ministry, under the coordination of a Mental Health National Coordinator.

While the National Steering Committee will keep its advisory tasks in the elaboration of Policies and Plans, the Department for Mental Health Development at the MoH will "absorb" the current Albanian Development Centre (so far financially supported by WHO) reshaping and strengthening it. The Department will formulate policy, plan and program proposals to be discussed at the NSC meetings before submitting them for approval, will be responsible for their implementation, will coordinate interventions in the field, will be responsible for promotion campaigns at national level, will advocate for mental health within and outside the ministry, at the political level, etc.

The Ministry of Health should appoint a small "Department for Mental Health Development" within the Ministry, under the coordination of a Mental Health National Coordinator.

Considering the dominant role that hospitals have had and still have, by being the main psychiatric service offered to the population, and considering as well the strong resistances to change encountered in the field, it is important to adopt a specific tool to proceed with de-institutionalisation, setting up a Deinstitutionalisation Group, gathering both Hospital

Directors and other Albanian and foreign experts on de-institutionalisation. This group should report to the NSC and work within the Department for Mental Health Development, being a functional part of it.

4.2 THE COMPOSING STRUCTURES OF THE COMMUNITY MENTAL HEALTH SYSTEM AND RELATIONSHIP AMONG THEM.

PRIMARY LEVEL OF MENTAL HEALTH CARE

Communities where individuals live, constitute the primary level at which health care operates. Mental health is a component of a more comprehensive health service and as such should be part of PHC teams' tasks.

Primary health care workers should get up dating training on community MH. The CMHC staff should supervise and collaborate with the PHC team related to the mental health issues.

Together they have to discuss through a comprehensive approach the cases identified by the PHC team, or by the social services, or referred back by the secondary level and to further plan their treatment.

The mental health care tasks of these PHC teams include the following:

- Provision of health care to both patients with mental disorders and those with unexplained physical complaints.
- Identification of patients who should be seen by visiting CMHC personnel or referred to the higher-level mental health facility.
- Identification of patients in whom physical symptoms indicate an underlying psychological problem.
- Provision of education on the maintenance of good mental health and liaison in this with other concerned and influential members of the community.
- Keeping a register of patients referred back to the community

Mental health is a component of a more comprehensive health service and as such should be part of PHC teams' tasks.

from higher-level mental health facilities and maintained on long-term medication, and ensuring continuity of treatment.
- Initiation of simple programs for personal development, such as training in relaxation techniques, promotion of recreational activities and exercise, counselling on involvement in community activities.
- Use of communication skills to mobilize and motivate mutual-support and self-help groups and to involve voluntary agencies in community development activities.
- Identification of individuals whose mental health may be under threat for any of a number of reasons, such as family stress, poverty, physical hardship, adverse working conditions, etc.

MORE SPECIFICALLY ABOUT THE SPECIALIZED SERVICES

The final shape that services will have in Albania will very much depend on the conditions at every district. In some cases the beds for acute care can be allocated into psychiatric wards within general hospitals, in other cases in community mental health centers covered 24 hrs.

In any case it is crucial that the therapeutic continuous relationship between the user and the team is kept. This can only be ensured by unifying the teams:

1. There where a psychiatric ward within a general hospital provides the acute in-bed care, is necessary to secure that it is the same team to cover the CMHC services, by mixing hospital and community based staff and by rotation shifts.
2. There where is the center itself to provide the acute in-bed care, this problem is smaller.
3. Admission into the psychiatric ward must always be performed in the framework of a continuity of community interventions.
   Emergency services in any case should be always integrated to the general emergency services at the hospitals.
   Often, emergencies can have relevant organic implications:

…it is crucial that the therapeutic continuous relationship between the user and the team is kept. This can only be ensured by unifying the teams

intoxication, organic syndromes, etc that require a comprehensive medical approach.

4. The main mean to secure continuity in the care, a comprehensive integral and integrated answer is to define and limit the responsibility of all these answers to a unique administrative organization, for a defined catchment area, with its own budget line and one accountable responsible.

The scenario described at item 1 could be a step on a transitional phase of downsizing hospital wards that can be followed by the scenario described at item 2.

What follows is a general description on how the services could look like in the future.

PSYCHIATRIC WARD

The psychiatric ward should offer care and advice to the various hospital wards and support to the general emergency service.

Admission into the psychiatric ward must always be performed in the framework of a continuity of community interventions carried out by the MH Centre to prevent this unit from becoming separate from or, even worse, alternative to the MH Centre.

The psychiatric wards should be dedicated only to the acute patients or long term mentally ill in acute crisis in need for in-bed treatment.

In this case, when beds for acute care are located in a hospital ward, mechanisms are to be identified. This will avoid any gap in between the ward and the community based services, for example, mechanisms that will facilitate mobilization or rotation of the personnel between the structures.

COMMUNITY MENTAL HEALTH CENTER

Community based Mental Health Centres (CMHC) provide

Community based Mental Health Centres provide services for the people residing within the zone of their competence. The CMHC also organizes prevention and rehabilitation activities, together with the PHC team.

services for the people (adults) residing within the zone of their competence.

The CMHC also organizes prevention and rehabilitation activities, together with the PHC team.

The multiple activities/services of the centre can be listed as follows:

- **Crisis intervention:** within the community, at home, at the prison, in the street, wherever the emergency occurs, the demand emerges
- **In-bed acute care:** Instead of the psychiatric ward within a general hospital this service can be provided in a CMHC, if this is supplied with 24hrs staff coverage and few beds for a defined geographic area.
- **Day hospital/hospitality** for some hours or the whole day with the goal to stimulate users' participation in recreational or guidance group activities.
- **Out patient visit**
- **Therapeutic work with the family**
- **Individual therapeutic work**
- **Group therapeutic work**
- **Rising self-awareness**
- **Interventions to build up a social network outside the family**
- **Rehabilitation:** direct and indirect interventions aimed at finding resources, programs, space, staff, professionals, whatever and whoever can be useful for work training, work integration, maintaining social and professional skills and guaranteeing access to information and culture.
- **Social and medical interventions**
- **Advice:** the CMHC establishes advisory relationships with the medical wards where clients of the CMHC are hospitalised.
- **Telephone**
- **Home care service**
- **Outreach teams**
- **Protected apartments,** specialised team sets up, manage and supervise protected housing. This is a community residential accommodation to maintain or learn social skills, relationship

…the time has come to consider the investments in children and adolescent mental health as cost-effective interventions, by preventing costs the society has to pay in the future.

skills, and coping skills to strengthen social rights. Protected apartments serve social and rehabilitative aims.

THE SYSTEM OF SERVICES FOR CHILDREN AND ADOLESCENTS' MENTAL HEALTH,

The System of Services for Children and Adolescents' Mental Health, needs a particular emphasis, based on one of the most important findings of the last decades' research in psychiatry and sociology, that suggests that the psychiatric morbidity in general and its financial burden, can be substantially reduced if early intervention is performed, so that early prevention is achieved.

This means that the time has come to consider the investments in the children and adolescents' mental health as cost-effective interventions, by preventing costs the society has to pay in the future.

Being that the aetiology of the mental disorders in early life is a complex issue, the children's treatment always needs additional inputs from the family and school environment, through multi-disciplinary and multi-modal models.

The System of Services for Children and Adolescents' Mental Health should work in the following directions:

- **Educational and Promotional Programmes**
- **Strengthening the primary care network** and enabling the primary health workers in the early identification of development and pervasive problems.
- **Training and qualification of the paediatric services** on a national level about increasing knowledge on child development and psychiatric problems of children and adolescents.
- **Establishing a specialized network of services** for children and adolescents' mental health on a national level.
- **Involving the professionals of child development** in the paediatric services of the country.
- **Training of children and adolescents' Psychiatrists** through a well-structured post-graduate programme in the field.

- **Focus on the specific problems** of the Albanian situation at present, such as: drug and substance abuse, coping with stress and trauma, criminality among children and adolescents, etc.

SOCIAL ENTERPRISES

The main aim of non-profit, social enterprises is to pursue the general interests of the community in human promotion and social integration of citizens. These enterprises can achieve this aim by managing different economic activities - agriculture, industrial, commercial - to provide employment for disadvantaged people especially in mental health aspect. Partners in this enterprise could be users of mental health services, mental health workers (nurses, technicians), unemployed youth, etc.

Social enterprises have also a task to explore hidden abilities, promote social inclusion and to contribute in general cultural transformation.

ASSOCIATIONS OF USERS OF MENTAL HEALTH SERVICES AND ASSOCIATIONS OF FAMILIES OF MENTALLY ILL PERSONS

The Mental Health Services in their planning and every day activities should include these associations. They should be autonomous and active, as a very important tool of community work and for advocacy of human rights of mentally ill persons. Strong cooperation should be established among CMHC, Social Enterprises and these associations.

In order to keep continuity in the care, to define responsibilities on the mental health care of a certain population and to avoid "shortcuts" among the services, the organization of all the above-mentioned structures under a unique umbrella, with a specific budget becomes essential. This modality of organization is the one used world wide to establish community care.

Associations of Users of Mental Health Services and Association of Families of Mentally ill Persons should be autonomous and active, as a very important tool of community work and for advocacy of human rights of mentally ill persons

4.3. HUMAN RESOURCES STRATEGIES

Different strategies to mobilise and better utilise human resources are dramatically needed in the Community MH field and exuberant within the hospital setting or in some other fields, should be proposed, discussed and defined. Relaxed procedures for managing the human resources are to be approved and applied.

a) From PHC: we should suggest how to concretely mobilise resources from PHC (through internal applications, for example, or part time involvement in two services, agreements of collaboration, by defining as well on whom concrete responsibility these decisions rely on, etc).
b) From the Psychiatric Hospitals: see above, on PHC. Additionally a survey can be conducted within hospitals to better understand what are the real resources contained, a review of the regulation of hospitals, increased international support to change, etc.
c) From other hospitals, services and sectors (as social and municipal services, NGO, private enterprises, non-profit, etc).

Key positions like those of department director or hospital and centers' directors should be held by motivated managers. Their commitments should be time and objective limited.

An incentive-based policy could be applied to favor the above mentioned necessary shifts and to handle the lack of qualified human resources in the rural areas.

Continuous up-dating training of current personnel on community mental health, rehabilitation, services' management, etc is necessary.

Continuous up-dating training of current personnel on community mental health, rehabilitation, services' management, etc is necessary.

Review and enhance training programs for the future generations of nurses, psychiatrists, psychologists and social workers.

Ensuring and reinforcing the long-term involvement of the social workers and psychologists in public mental health structures.

Creation of new, intermediate professional profiles like the one

of social rehabilitation, educator, animator, instructors, health agent, etc is to be envisaged for the future.

4.4. MONITORING

A standardized monitoring system is to be set up. Indicators of quality of services, quality of life, etc need to be individuated. This will allow quality monitoring of the services, their impact on users' life, their functionality and capacity to answer to citizens' expectations, among other aspects. On the basis of the systematically collected data the actions undertaken to reform the system can be reviewed and improved.

5. MENTAL HEALTH AND LEGAL FRAME

Human Rights are a fundamental concern in Mental Health.

This committee is aware of the many deficiencies of the current institutional settings that can frequently lead to violations of patients' human rights.

Its main objective is to set up proper services, giving professionals the proper tools to fight discrimination and secure the right to access care when needed.

The Albanian Parliament approved the Mental Health Act in Albania in 1996. At that time, this was a step toward raising institutional awareness on the human rights of the mentally ill; meanwhile Albania was rapidly getting insight on the importance of the human rights issues in general.

However, it can be suggested that in the current context, the legal frame in Albania has to be reviewed in order to be compatible with:

a) The current situation of a locally owned action in the field of the Mental Health reform.
b) The parallel development of a social protection system reflecting the development stage of the Albanian society.
c) A clear and non-equivocal definition of the community mental health system.

Finally, instruments to monitor and denounce human rights violations are to be defined, reinforced and applied in the following: (i) violations occurred within the mental health services system, and (ii) violations occurred outside the mental health services system, but addressed against the mentally ill.

The main objective is to set up proper services, giving professionals the proper tools to fight discrimination and secure the right to access care when needed.

6. A PROPOSAL TO START:

The MoH declares:

"Tirana Demonstration Mental Health System Nr.1" (TDMHS1)

Considering the current situation of the psychiatric and mental health services of Tirana, the existing local and international resources, the current lack of a referral system and reciprocal/respective responsibilities that services show towards their users and towards each-other, the TDMHS1 proposes a demonstrative mental health department, financially well defined and with dependency from the Regional Health Authority (RHA)

TDMHS1 has:

a) A catchment area defined as the area of the mini-municipalities no. 5, 6 and 7 of Tirana.

b) One unified multi-disciplinary team with mixed origin (from the Psychiatric Department of the Tirana University Hospital Center - PD TUHC and the Community Mental Health Center - CMHC /near the Polyclinic nr.9).

Both those services should respectively offer as follows[5] :

PD TUHC	**CMHC**
1 psychiatrist	3 psychiatrists
4 nurses + 2 caretakers/instructors	6 nurses
1 psychologist	2 psychologists
1 art instructor/social worker	2 social workers

c) A clearly defined budget allocated to the TDMHS1, with the agreement and contribution of different Departments of the Ministry of Health.

d) Two spaces, respectively in the Polyclinic 9 and in the Department of Psychiatry of UHCT, which through the described team, will offer in bed services, day care, rehabilitation activities,

[5] That does not mean that the resources offered by the hospital shall change their working station. Indeed, their work should be redefined according to the terms of reference of the TDMHS1

etc. All of the above will ensure continuity of care for the patients of the approved catchment area[6].

The Head of the TDMHS1/Department will refer and respond to an entitled officer of the Ministry of Health (linked with the NSC until establishment of the Department of Mental Health) and be considered as a dependent of the RHA.

The resources of the TDMHS1 will assist (according to the following terms of reference) also the other mental health structures that provide mental health services for the users of the approved catchment area (Alternativa, Fountain House, etc), and that are currently under external or international funding.

This assistance is considered to be the first step of the public funding offered to those structures, as the staff of the TDMHS1 paid by public funding will offer time to those structures.

The terms of reference of the TDMHS1 are as follows:

a) Provide mental health services to the community of the approved catchment area (including home care, day care, long term rehabilitation and social support, prevention, promotion, social enterprises, etc).

b) Provide mental health care to the clients of the approved catchment area that need hospital admission.

c) Provide reforming acts within the psychiatric Department of the TUHC (rehabilitation programmes)

d) Set up de-institutionalisation programs and define steps to implement them for the long-term residents of the psychiatric hospitals of the country that originate from the approved catchments area.

Monitoring and evaluation of the technical aspects of the work of the TDMHS1 is to be designed and performed by the National Steering Committee for Mental Health.

TDMHS1 should be baptized and recognized by the MoH itself through an official paper/agreement that accepts its composure, terms of reference, financial aspects and also ensure the agreement between RHA and University Hospital Center of Tirana on staff arrangement.

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[6] The Department of Psychiatry of the UHCT shall offer 6-10 beds for in bed services to the patients of the approved catchment area.

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4. Strategy Document on the development of Mental Health of Children and Adolescents in Albania, March 2002.

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OPERATIONAL PLAN FOR MENTAL HEALTH SERVICES DEVELOPMENT IN ALBANIA

Nr. 1461 Prot.

Tirana, 13 May 2005

REPUBLIKA E SHQIPERISE
MINISTRIA E SHENDETESISE

ORDER

NR. 226, date 13/05/2005

In frame of the mental health reform, as well as in support to the Policy for Mental Health services development,

I ORDER:

1. The approval of the Operational Plan for the Mental Health Policy in Albania.

2. The following are requested to implement this order: Directory of Primary Health Care, Directory of Hospital Care, Directory of Human Resources, Directory of Economics and all other institutions involved in the Plan.

3. This Order enters into power immediately.

THE MINISTER

Leonard SOLIS

(signed and sealed)

The original copy of the order of Minister of Health is found in page 41 of the Albanian section of this document.

Following the approval of the policy document the National Steering Committee for Mental Health (NSC) constituted a working group mandated to develop and submit the operational plan for the policy. The group was composed of:

Prof Anastas Suli - Head of the NSC, Head of Department of Psychiatry at the University Hospital Center "Mother Teresa"
Dr Ariel Çomo - Department of Psychiatry at the University Hospital Center "Mother Teresa"
Dr Erol Çomo - Member of the NSC, Ministry of Health
Ms Dévora Kestel - WHO Country Office Albania
Dr Ledia Lazëri - WHO Country Office Albania

The Operational Plan for Mental Health Services in Albania received, during November 2004, comments, suggestions and recommendations from about 100 mental health workers, health authorities at national and regional level, representatives of the users and family groups, representatives of the civil society, and international partners.

All their valuable inputs were inserted in the present document which represents a consensus of all relevant partners and stakeholders in planning and implementing the mental health reform in Albania.

The Working Group of the National Steering Committee for Mental Health wishes to thank them all and expresses its appreciation for their careful consideration and thoughtful responses.

Special acknowledgment and thanks go to the World Health Organization.

The technical inputs and political support from the WHO County Office Albania, WHO

[1] The Working Group received technical assistance from Mental Health: Evidence and Research, Department of Mental Health and Substance Abuse, WHO Geneva (Drs M van Ommeren and S Saxena).

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This document is a 5-year operational plan to implement the Policy for Mental Health Services Development in Albania (2003). The Policy's long-term vision is the existence of community mental health services that are accessible, comprehensive, effective, and respectful of human rights, throughout the country.

The first phase of activities will be implemented in four catchment areas (defined geographical areas) where presently the large psychiatric wards and hospitals are located: Tirana, Elbasan, Vlora and Shkodra. This will facilitate building models for moving resources from the hospital to the community and for developing community mental health services, while avoiding fragmentation of efforts. This first phase will be evaluated and studied to inform the development of a community infrastructure throughout the country.

That is, prioritizing these catchment areas does not mean that the Operational Plan is discriminating / differentiating the rest of the country. Rather, the plan first focuses on areas where the development of community services is most feasible from a financial and programmatic perspective and then expands to the rest of the country. At the same time, the Plan defines many activities with country wide coverage, e.g.: the establishment of the Mental Health Sector in the Ministry of Health, the revision of the Mental Health Act, the monitoring system, the training for health and mental health professionals and the promotion activities have an impact that will cover the entire country map of health system.
They will be implemented alongside a continuous timeline that follows the timeline of the Plan in general.

The Plan includes an organogram for the organization and configuration of services and staff at the level of priority areas. The organogram describes the minimal human resource requirements for a prototypical catchment area of about 150,000 people.

This operational plan covers activities for a 5-year period (January 2005- December 2009), while providing details of those activities that are to be implemented during the first two years (January 2005- December 2006). After two years (January 2007), there is a need to review what progress has been made and to detail the activities for the following three years (January 2007- December 2009).

The following activities (for January 2005- December 2006) are described in detail in the plan:

- Establishment of a technical Mental Health Sector within the Ministry of Health to ensure coordinated implementation of community mental health services along with deinstitutionalization.
- Revision of the Mental Health Act (1996) to ensure human rights and to implement law.

- Development of community mental health teams in the four priority catchment areas to deliver care in the community to inpatients and outpatients, whether in community health centres, general hospitals, or supported accommodation.
- Discharge of long-term patients (from the four priority catchment areas) into community care (deinstitutionalization) to improve the human rights situation of the mentally ill. This involves:
  - Developing specific plans for deinstitutionalization of each institution, including staff training and resource shifting.
  - Individualized case plans to ensure continuity of care after discharge
  - Stop long-term admissions from the four priority catchment areas and to stop inappropriate admissions from other areas
  - Income generation activities to increase the capacity of patients to live outside the hospital and to facilitate social reintegration
  - Family activities to increase family members' capacity to care for and live with mentally ill people
  - Housing activities to facilitate that discharged patients can live in the community
- Capacity building and refresher training of mental health professionals to ensure effective and up-to-date care.
- Training of primary care workers to identify patients with disorders, to treat patients with common mental disorders, and to refer patients with severe mental disorders.
- Monitoring system to facilitate planning and accountability at the services-level and to ensure continuity of care at the patient-level.
- Elaboration of an activities plan to promote mental health

For each of the above activities, the operational plan systematically provides information on the target group, the activity's purpose, a description of the activity, baseline data on the activity, the target to be achieved (with deadline), the implementation plan (with specification of the responsible institution), potential barriers for implementation, indicators for evaluating the activity, the estimated financial and non-financial resources required, and the potential financing institutions.

This development initiative builds on experiences and lessons from existing efforts to build the community mental health system. Preliminary data from the development of the Tirana community centre suggests that a major impact can be made on hospital admissions. Also, changes in the screening and admissions structures at a hospital – as in Vlora – can also contribute to reductions in admissions. These findings suggest both models and the feasibility of the initiatives proposed in this plan. See page 26.

In order to identify the latter, an analysis of the financing of mental health services in Albania was performed during 2004, intending to obtain current data on hospital services and budgets and on community services so that an overall mapping of financial resources for mental health could be developed. As this analysis indicates, there is a window of opportunity to build the community

infrastructure through the support of external donors. Funding from external donors has been decisive in addressing the issue of one-time fixed capital costs which are necessary for building the community-based system. This plan proposes activities to take advantage of the availability of such resources.

The Operational Plan specifically entails the commitment and the financial accountability of institutions other than the Ministry of Health.

The Ministry of Labour and Social Affairs is considered to be an important partner as the complex needs of the mentally ill require the dedication of the entire network of the social system of care.

The local government becomes an increasingly important partner in the establishment of the mental health care system. With an advancing decentralisation process, it will soon be on the local governments' mandate to provide solutions for the needs of the respective populations, including the needs of the mentally ill.

The Non Governmental sector is a valuable partner of the public services with its unique information about the mentally ill population, expertise in alternative services and resources already allocated to the care provision,

The Working Group of the National Steering Committee for Mental Health recommends the implementation of this 5-year operational plan to achieve the vision described in the Policy for Mental Health Services Development in Albania (2003) to reduce the burden of mental disorders in Albania and to improve the human rights situation of people with severe mental disorders.

I. INTRODUCTION

This operational plan follows the Policy for Mental Health Services Development in Albania. The Policy, written by the National Steering Committee for Mental Health, was formally approved by the Minister of Health on March 2003, after a long and complex process of assessment, consultations and debates, held both at the national and district level, under technical support of international expertise, in collaboration with WHO.

The legislative foundation of the Policy is the Mental Health Act, approved by the Albanian Parliament in the year 1996. This Operational Plan aims to implement the Act at all levels and areas that are linked with mental health services development.

The vision for community mental health services development in Albania - including the organization and functions of different service components - is described in detail in the Policy document. The Policy defines the national goal and the strategic key points to reach it, describes the community mental health system from both the organizational and technical perspective, proposes the strategies of monitoring and of developing local capacities, emphasizes the need for reviewing the legislative frame, and describes a demonstration system of mental health services in Tirana.

The Policy states explicitly that the national goal of mental health development in Albania is the establishment of a community mental health care system across the country.

As requested by the Policy, the implementation strategy (operational plan) intends to define and describe realistic, sustainable activities with clear objectives, timetable, indicators and plan for implementation.

This is a 5-year operational plan (January 2005- December 2009) with details of the activities to be implemented for a 2-year period (January 2005- December 2006). After two years (December 2006), there is a need to review what progress has

This operational plan follows the Policy for Mental Health Services Development in Albania. The legislative foundation of the Policy is the Mental Health Act, approved by the Albanian Parliament in the year 1996.

been made and to detail the activities for the following three years (January 2007- December 2009).

This operational plan is supported by comprehensive action undertaken by the Albanian government in collaboration with a number of intergovernmental organizations (e.g. WHO, UNOPS/PASARP). Since 2000, a series of interventions performed in different areas of the country have enhanced the commitment by both local mental health professionals and authorities at the central level. Those interventions allowed the fulfilment of many tasks, such as the completion of the project on monitoring mental health system and services, the action plan for the de-institutionalisation of the psychiatric hospital of Elbasan, the cost analysis of psychiatric services in Albania, and the establishment of community based mental health services in Tirana, Shkodra, Elbasan, Gramsh, Peshkopi and Vlora.

II. IMPLEMENTING THE POLICY: OVERALL STRATEGY

Comprehensive mental health services will be developed for each of the country's catchment areas. A catchment area is a geographic area served by the mental health system of services and delineated on the basis of such factors as population size, existing administrative boundaries, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area should be able to have their need for services meet within their catchment area. It is envisioned that in Albania mental health services' catchment areas will cover approximately 100.000 to 150.000 people living in defined areas.

Activities will first be implemented in the four catchment areas where the large psychiatric wards and hospitals are presently located: Tirana, Elbasan, Vlora and Shkodra.

The four catchment areas are prefecture centres and they cover[2]:

1. Elbasan district with a population of 221.635 (Elbasan city with 95.554 inhabitants / Elbasan communes – rural areas with 126.081 inhabitants);
2. Shkodra district with a population of 185.395 (Shkodra city with 85.798 inhabitants / Shkodra communes – rural areas with 99.597 inhabitants)
3. Vlora district with a population of 147.128 (Vlora city with a 85.180 inhabitants / Vlora communes – rural areas with 61.948 inhabitants).
4. Tirana city with a population of 352.581 inhabitants (the catchment area of the Community Mental Health Centre of Tirana – a subdivision of the above population – consists in 111.062 inhabitants).

These four areas will be referred to as 'priority catchment areas'. The reasons why they are prioritized is to ensure discharge of long-term

Comprehensive mental health services will be developed for each of the country's catchment areas. .... It is envisioned that in Albania mental health services' catchment areas will cover approximately 100.000 to 150.000 people living in defined areas.

[2] Population data extracted from "The Population of Albania in 2001", © INSTAT 2002

inpatients into newly developed community mental health care, which is required according to the 1996 Mental Health Act and the 2003 Policy. Those four areas are the richest ones in terms of mental health resources, and therefore it will be easier to move resources from the hospital to the community, while avoiding fragmentation of efforts. Any successful outcome of those efforts would demonstrate the advantages of the steps undertaken by this Plan and would facilitate the further implementation in the rest of the country.

As mentioned above, the findings from the hospital data (see page 78) suggest the feasibility of the initiatives developed in this plan. An important aspect of plan implementation will be the development of appropriate monitoring systems to record the processes, outcomes and resources required to develop these structures and programs.

For a general description of the community mental health system, see page 27 of the Policy described in this document. For a more extensive description of the envisioned community mental health system, see the Policy's annex 'Community Mental Health Structures and Relationships Among Them.' For a description of deinstitutionalization, see pages 20.

To develop mental health services in Albania consistent with the Policy, the following steps will be implemented:

1. Demonstration project in Tirana (ongoing).
2. Implementing a rational admissions policy in the four institutions (ongoing).
3. Building community mental health services in the four priority catchment areas - covering inpatient/outpatient care, primary health care (PHC), and supported accommodation - along with discharge of long-term residents patients from the four priority catchment areas into community care (2005-2007). This whole action requires redistribution/reallocation of the existing budget for the psychiatric institutions and services. Hereby, the reallocation of the budget does include the flexible use of human and physical resources, as well as the functioning of the institutions and services. Furthermore, the allocated budget shall be earmarked / conditioned to be used only for the mental health services needs and activities.
4. Building community mental health services in the remaining

This whole action requires redistribution/ reallocation of the existing budget for the psychiatric institutions and services.

catchment areas - covering inpatient/outpatient care, PHC, supported accommodation - along with discharge of the remaining long-term residents/patients into community care (January 2007- December 2009).

Aforementioned steps will be implemented along with:

- Structural development of mental health coordination (e.g. establishment of a Technical Mental Health Sector in the Ministry of Health (MoH); appointment of Regional Mental Health Coordinators; appointment of Coordinators to lead interdisciplinary community mental health teams in each catchment area, etc).
- Revision of the Mental Health Act of 1996
- Upgrading of university training of mental health professionals and primary health care professionals.
- Regular refresher training of mental health professionals and primary health care professionals
- Mental health promotion and prevention activities
- Development and implementation of a system to monitor the Albanian mental health system and services.
- Inclusion of a national family association representative and a service users' representative in the National Steering Committee for Mental Health.

An organogram has been developed for the organization and configuration of services and staff at the level of catchment areas (see Figure page 90). The organogram describes the minimal human resource requirements for a prototypical catchment area of 150,000 people. In such a catchment area, there will be a community mental health centre (incl. day centre). Acute and medium-term inpatient care will take place either at the community mental health centre or at the general hospital.

The community mental health service will work in collaboration with (a), primary health care services (b) general hospital (physical) medicine, (c) Social Affairs Ministry (for housing and income generation activities), (d) relevant NGOs, (e) police and prison services, (e) relevant professionals in the school system, (f) private practitioners, (g) substance abuse services, and (h) informal care givers (clerics, family members).

An organogram has been developed for the organization and configuration of services and staff at the level of catchment areas.

III. MENTAL HEALTH FINANCING[3]

Overall, financing levels for Albanian health care remain very low and as a report of the European observatory on Healthcare Systems (2002) indicates, "for the last decade, the health sector emphasis has been on how to do more with less". Even though hospital care has received priority, Albania's ratio of hospital beds to population is among the lowest in Europe and, even though life expectancy is relatively high and compares favourably with other European countries, other health outcomes and indices do not fare as well.

Albanian health services are funded through a mix of taxation and statutory insurance with the major part of funding provided through the state budget. The Ministry of Finance allocates money to the Ministry of Health and provides local governments with earmarked funds, mainly for primary care, (In the year 2000, this local support amounted to 4 percent of the state health budget).

The Ministry of Health is the major funder and provider of health care services. Hospitals and many other health care institutions are under the direct administrative control of the Ministry. The Ministry is also responsible for administering foreign aid in the health sector and for regulating the growing private sector. The Ministry of Health is responsible for funding non-physician staff and specialized care. The psychiatric hospitals and district hospitals are administered directly by the Ministry of Health.

The Ministry of Health is the major funder and provider of health care services. Hospitals and many other health care institutions are under the direct administrative control of the Ministry.

Another source of health financing is the Health Insurance Institute (HII). The HII is a national statutory fund which was granted autonomy as a quasi-governmental body in 1999 accountable directly to Parliament. HII is financially responsible for primary health care doctors and essential pharmaceuticals.

Under the HII rubric, a new model of a regional health authority was introduced in Tirana in the year 2000 with the assistance

[3] The material is extracted from the Health Economist Consultant Site Visit Report, Tirana, August 22 -27, 2004

of DFID and the World Bank. Primary care and public health programs are integrated under the Tirana Regional Health Authority so that there is a single entity that is responsible for their planning and management. A regional health board has been set up and is responsible for endorsing proposed regional policies, plans and budgets. In this Tirana pilot, the HII funds all primary health care expenditures, including salaries of doctors, nurses and other personnel, as well as the recurrent costs for these services. This regional pilot is intended to serve as a model for the regionalization of health services in other parts of the country.

As part of this regional health authority design for the future, the Policy for Mental Health Service Development launched the Tirana Mental Health Demonstration System project. In this project, an already established community mental health center was integrated with one ward of the psychiatric clinic of the University Hospital Center "Mother Teresa" to cover one catchment area of Tirana while the other catchment areas continue to receive more traditional psychiatric ambulatory care. A clearly defined budget has not yet been allocated to the mental health demonstration project. Nevertheless, the allocation of a clearly defined budget to the Community Mental Health Center of Tirana is significant from a mental health financing perspective because it has the potential of providing an understanding and defining the benefits of this model so that it can serve as the rationale for a country-wide community-based mental health system.

The data with regard to the financing of mental health services in Albania, do suggest that the proportion of health expenditures allocated to mental health are relatively high – 6 percent – but this is misleading because the actual expenditures for health are relatively low. That is, the absolute amount allocated to mental health is still relatively low when compared with other European countries. A large proportion of mental health expenditures – 66 percent – are allocated for psychotropic medicines, (Monitoring Mental Health Systems and Services Project March, 2004).

… the absolute amount allocated to mental health is still relatively low when compared with other European countries.

It also appears that the trends for psychiatric hospital costs are relatively constant. Any increases appear tied to increases

in personnel costs. The cost for an inpatient bed-month at Elbasan was 37,311 leks while the equivalent cost at Vlore was 25,974 leks.
Projected annual personnel costs for setting up a catchment area community team was approximately 3 million leks.

Clearly, a larger range of services were available through a Community Mental Health Center than the more traditional psychiatric clinics but at a higher cost. Although, referring to a simple study in Tirana, the services offered from the Community Mental Health Center decreased the admissions from the catchment area of the Center (see activity 2.a - Development of community mental health services for both inpatients and outpatients). That is, as community models are implemented for persons in hospitals, there should be possibilities of transferring some resources from hospital to community settings, either through reductions in census that can be translated into staffing and resources reductions, or through other efficiencies in hospital management.

As the development of the community mental health centers indicate, the funding from external donors has been decisive in addressing the issue of the one-time fixed capital costs which are necessary for building the community-based system. As a matter of fact there is a commitment from several agencies and donors to continue with funding for these capital costs. The challenge is how to sustain the running costs of these community programs. A partnership with external donors is a possible option: external donors bearing the responsibility for the fixed one-time capital costs and Ministry of Health or HII assuming responsibility for the running costs.

An important component of plan implementation will be the development of mechanisms to assess and monitor costs of developing the community mental health system.

An important component of plan implementation will be the development of mechanisms to assess and monitor costs of developing the community mental health system. This will allow for realistic projections of the resources that will be required for expanding community mental health services throughout the country.

IV. OPERATIONAL PLAN TO REFORM THE SYSTEM

IMPLEMENTATION OF ACTIVITIES START BY 1 JANUARY 2005

Activities have been selected on the basis of priorities. Activities that include predominantly 6-month targets or sub-targets are described as emergency/ immediate activities. The word emergency is used, because the present state of the mental health system needs emergent intervention for improving and guaranteeing the human rights of the mentally ill. This is not only mandatory following the international Conventions and Treaties ratified by Albania during the last decade, but also in frame of the existing Mental Health Act approved by the Albanian Parliament since 1996 but still not implemented.

Activities that include predominantly 24-month targets or sub-targets are described as short-term activities.

I. EMERGENCY/ IMMEDIATE ACTIVITIES (6 MONTHS)

1A) ESTABLISHMENT OF A TECHNICAL MENTAL HEALTH SECTOR WITHIN THE MINISTRY OF HEALTH (MOH).

Purpose and description: WHO recommends that all member states have a national-level government mental health authority to ensure coordination and implementation of community mental health services along with deinstitutionalization.

In Albania, this technical Sector will exist of at least two mental health professionals.

The responsibilities of the proposed Sector include:

- To make recommendations to the highest levels of the government on mental health policy and legislation.
- To design national mental health plans.
- To coordinate and supervise the implementation of mental health policy, legislation, and plans.
- To provide technical supervision to Regional Mental Health Coordinators (see organogram)
- To supervise the capacity building and promote the incentive policies for the human mental health resources
- To coordinate cost-effective use of resources, including the transfer of resources from institutional to community care.
- To conduct quality assessment and promote best practices.
- To liaise technically with other Ministries
- To monitor and evaluate the mental health system and its services and to report findings annually.

WHO recommends that all member states have a national-level government mental health authority to ensure coordination and implementation of community mental health services along with deinstitutionalization.

Activities may be delegated by the Sector to third parties. The National Steering Committee for Mental Health, with new Terms of Reference after the approval of this Plan, will be a source of advice to the Sector (see organogram). The World Health Organization will be another source of advice using its technical expertise and mobilising its sources. The National

Steering Committee for Mental Health will include a member of national family association to ensure inputs from family members.

Current situation: There is no national government unit/ entity/authority in the area of mental health.

Overall need: A technical mental health Sector should be established in MoH.

Target with timeframe: Existence of a technical mental health Sector in MoH (from 1st January 2005).

Implementation plan: MoH responsible to follow up the achievement of the Sector in place.

Possible barriers to implementation: A government decision to postpone the establishment of this Sector.

Indicator(s) for evaluation of activity: Presence of national government Sector in the area of mental health in Albania.

Activity implementation details	
Responsibility for implementation	The Minister of Health and the Director of the Department of Public Administration.
Estimated Cost 2005-2007	960.000 Leks/person (salary and insurances). Capital start up costs.
Other resources required	Office space in MoH
Financing	Ministry of Health (salaries and insurances) and WHO Country Office Albania (capital start-up costs)

1B) DISCHARGE OF LONG-TERM PATIENTS INTO COMMUNITY CARE (DEINSTITUTIONALIZATION).

Purpose and description:

The aim of discharging long-term patients has been explained in detail in the Policy document. A long-term patient is defined here as a patient who has stayed longer than one year in the psychiatric wards or hospitals of Tirana, Elbasan, Vlora and Shkodra. In brief, deinstitutionalization is first and foremost essential to improve the human rights situation of the mentally ill. Deinstitutionalization leads the way to the establishment of mental health services that are accessible, comprehensive, effective, and respectful of human rights. People who leave the institutions will live (a) in supported accommodation (e.g., a house with 24-hours care), (b) with their families or (c) on their own or with other ex-hospital residents. Some ex-hospital residents may first live in supported accommodation before moving to their families or living on their own.

In the meantime, those that will not have immediate access to the supported accommodation will benefit from proper living conditions in the wards and will be cared of by a staff properly trained to provide care in full respect of human rights.

Deinstitutionalization is a complex task, consisting of a range of sub-activities. First, mental health care should be made available in the community. This is important, because patients who are discharged need to receive care in the community. Hence, inpatient/outpatient care in the community by community mental health teams needs to be available. To ensure continuous availability of such care, not only the flexible use of the existing budget is needed, but also additional budget in terms of human and physical resources will be available. The existing allocation of the resources is not linked to the service delivery of the respective health care facility, either in quantitative or qualitative terms. Instead, the budget allocation should be linked with the performance indicators of the service delivery to the population of the respective catchment areas. The establishment of an integrated monitoring system of overall services and individual care (see activity 2c) will provide data about performance indicators that should facilitate a further process of budgeting

… deinstitutionalization is the first and foremost essential to improve the human rights situation of the mentally ill.

the mental health services.
Considering the wide range of activities to attain deinstitutionalization, the social care system should become accountable for establishing the network of the supporting services for the mentally ill. The Ministry of Labour and Social Affairs, as requested by the Mental Health Act 1996 articles 7, 8, 9, 14 and 44, is responsible for coordinating resources with the Ministry of Health in providing the comprehensive community based mental health care.
For details of the deinstitutionalization activity, see activity 2a.

Current situation:
There is one mental hospital in Elbasan and one mental hospital in Vlora. Moreover, there is one psychiatric ward in Tirana and one psychiatric ward in Shkodra (1 unit within the psychiatric ward of Tirana is for children and adolescents).
Note: these general hospital wards are very similar to the mental hospitals and are therefore discussed here, rather than in the section on community services.

Thus far, 10 patients out of the 53 long term residents of the psychiatric ward of Shkodra have left the ward. It is since the year 2001 that those ten are sheltered in the protected house "Casa Mimosa" (under financial and technical support of UNOPS/PASARP).

Four other patients out of 22 long term residents of the psychiatric ward of Tirana left the ward in October 2004 to live in a private protected accommodation supported by the Communita' di Sant'Egidio.

Human resources at the four institutions:

	Psy--chiatrists	Other medical doctor, not psychiatrist	Nurses	Psycho--logists	Ergo--therapist	Auxiliary hospital staff
Psychiatric Ward - Tirana	13	0	40	1	2	31
Psychiatric Ward - Shkodra	2	0	18	0	3	17
Mental hospital Elbasan	7	0	50	0	3	117
Mental hospital Vlora	5	1	35	0	2	93

Within Regional General Hospitals of the country there are so-called "neuro-psychiatric beds in general wards" but the common practice is that these beds are used for neurological patients only. Psychiatric patients - if in need of hospitalization - are directly referred to the mental hospitals in Vlora and Elbasan or to the psychiatric wards in the general hospitals in Tirana and Shkodra. Seldom are the neuro-psychiatric beds in general wards countrywide used for emergency cases if the immediate transferral to the psychiatric wards elsewhere appears impossible/problematic. However, the use of those beds under the above circumstances lacks the due expertise, human resources and proper supervision.
Furthermore, there is no clarity regarding the official status of psychiatric beds in general wards, placed in general hospitals. This leads to confusion regarding the number of those beds that are not evidenced in the Ministry of Health data.

Overall need
Long-term patients in hospitals in Albania need to be discharged into community care, starting from the ones belonging to the four priority areas.

Targets with timeframe
At least one third of the long-term residents who are originally from the priority catchment areas where the hospitals are located (Tirana, Elbasan, Vlora and Shkodra) will be discharged into community care (by December 2006). As described previously, there are 161 long term residents that are originally from the four priority catchment areas.

Possible barriers to implementation:
Absence of an empowered national mental health sector in MoH to oversee resource shifting.
Lack of resources (both financial and human) to perform the needed actions on de-institutionalization.

Indicator(s) for evaluation of activity:
Percentage of long-term residents from the priority catchment areas who have been discharged into community care. Percentage of re-admissions to mental hospital within 30-days of discharge and within 1-year of discharge. Number of beds in hospitals.

Long-term patients in hospitals in Albania need to be discharged into community care, starting from the ones belonging to the four priority areas.

There are three main sub-activities crucial to achieve deinstitutionalization:

(1) Institutional and individualised case plans,
(2) Stop admission activities from the four priority catchment areas for long term purposes and
(3) Housing activities

Those three main sub-activities are prioritised in this Plan as the foremost actions that lead to the discharge of the long-term residents of the psychiatric hospitals.
Furthermore, this process is strongly facilitated by complementary activities like

(4) Income generation and
(5) Family activities.

1) Institutional and individualized case plans: As the four institutions differ in various ways (e.g. patient loads and resources), each institution should have their own tailor-made plan on how to discharge long-term patients to the community and how to move resources into the community.

Even though capital investments to start new community mental health services are necessary, flexible use of resources makes community services affordable and ensures that the decrease in size of the institution is not temporary. Staff in institutions will need to be trained to work in the community, because the nature of the work is very different, but also will need to be trained in psychosocial rehabilitation so that they can help prepare patients for discharge. As patients differ in important ways, individualized case plans (with psycho-social rehabilitation components) need to be made that describe each patient's diagnosis, capacity, disability, original place of residence, family situation, potential social benefits and potential ways of discharging the resident into community care. As the financing analysis indicates, external donors can play a critical part in providing resources for these capital investments and initial start-up costs.

…each institution should have their own tailor-made plan on how to discharge long-term patients to the community and how to move resources into the community.

Individualised case plans will consider as well those patients

that, for one reason or for another, will not have immediate access to supported accommodation. That means that the physical conditions of their living and the care provided by the staff will guarantee human dignity and will meet their basic individual needs.

Current situation: None of the four institutions currently have tailor-made institutional-level plans on moving resources to the community.

In Elbasan and in Vlora the personnel of the hospital have started to plan to discharge patients based on individualised considerations of their personal situation, family conditions, economic potential, etc. To achieve that, the personnel have completed the psycho-social assessment of all patients from both hospitals, thus allowing the further elaboration of institutional and individualized case plans.

There are initiatives from the hospitals' management to improve the living conditions inside the wards. This however might require capital investment that the MoH should take into account while planning the budget for the next period.

Overall need: All four institutions should have a tailor-made plan on how to move patients and resources to the community. The long-term goal is to shift, as much as possible, to the community the resources associated with long-term hospital care. All human resources that shift to the community should be trained (see activities 1c and 2a). All four institutions should have individualized case plans.

At the same time, there needs to be recognition that there may be a lag between the development of community systems and the ability to transfer resources from hospitals to the community. Only when a sufficient number of hospital beds can be closed can such "lump-sum" resources become available for the development of community resources. However, with the increased orientation of hospitals to promoting a community-based system, there are changes that can occur to facilitate the use of hospital resources for community services development.

Targets with timeframe: All four institutions will have a tailor-made plan on how to flexibly use their resources (by June 2005). All four institutions should have individualized case plans for those residents from any of the four priority catchment areas (by June 2005). All four institutions should immediately start to improve the living conditions of their residents, as a very basic initial step towards the dignity and respect of their human rights.

Implementation plan: Through the establishment of local boards (composed of local mental health professionals, health authorities, local government's representatives and Ministry of Labour and Social Affairs representative at the local level) a short, medium and long-term institutional plan will be defined for each institution. Through a common tool developed for this purpose, detailed individualized plans will be made, initially for those patients belonging to the 4 priority areas.

Possible barriers to implementation: Different priorities in the hospitals other than the above thus delaying the elaboration of the plans.

Indicator(s) for evaluation of activity: Existence of plans for each institution. Percentage of patients in each of the four institutions with individualized case plans for discharge. Percentage of hospital staff that is trained in community care.

2) Stop admission activities: One essential component of deinstitutionalization is a rational admissions policy, which means to (a) drastically limit admissions for long-term care for psychiatric patients from the four priority catchment areas, starting immediately, (b) aim to stop admissions for long-term care for psychiatric patients from the four priority catchment areas, and (c) stop inappropriate admissions for long-term care (eg people with mental retardation), starting immediately. Development of a special admissions service is essential to implement a rational admissions policy. Each of the four institutions will need to develop referral criteria that are relevant for the level of resources in the region that they are in.

At the same time, there needs to be recognition that there may be a lag between the development of community systems and the ability to transfer resources from hospitals to the community

Current situation: Two out of four institutions (Vlora and

Shkodra) currently have an admissions service and new admissions procedures. Elbasan is proceeding in averting the inappropriate admissions and has already limited the admissions of people with mental disability thus gradually implementing appropriate referral criteria. As reported by the hospital's management, in 2003 there have been 21 cases that were admitted for a limited stay (not for a long term as previously) in the hospital under the diagnosis "Mental Retardation". In 2004, following the priority of the Policy Document about gradually stopping the inappropriate admissions, the hospital management succeeded in reducing the above number in 11 cases.

Tirana has an admission/emergency service, but the referral criteria for admission in general are mixed up with the emergency service provision criteria.

Overall need: All four institutions should have an admissions service and admissions procedures with referral criteria.

Targets with timeframe: All four institutions will have an admissions service (by December 2005) and implement rational admission procedures, including referral criteria (by December 2005).

Implementation plan: See description of this sub-activity (above).

Possible barriers to implementation: The lack of community mental health services in the rest of the country might be a substantial barrier to stop the inappropriate admissions from those areas.

Indicator(s) for evaluation of activity: To have an admission service in place ensuring this activity. Percentage of new patients in each of the four institutions that come from the four priority catchment areas. Number of inappropriate admissions averted through the admission service.

Development of a special admissions service is essential to implement a rational admissions policy.

3) Housing activities: Living in the community in supported accommodation will provide dramatic improvements in quality of life and will help re-establish more natural social networks

for the mentally ill. It is envisioned that groups of no more than 10 ex-hospital residents will live together in supported accommodation, so to avoid trans-institutionalization. The needed staff for a house of 10 people, 24 hours per day, seven days per week, is estimated to be 8 full-time caregivers (e.g. nurses) (see organogram). These care-givers need to be trained and supervised (by the multidisciplinary team).

The supported accommodation will not only serve as a real shelter for many of the currently institutionalised patients, but will also be transitional facilities for patients towards an independent living in the best of the cases, or towards a least assisted living as possible.

Current situation: Presently there is Casa Mimoza supported accommodation in Shkodra (see activity 2a for a description of the staff in this centre) and the recently opened Family House supported by private funds from Comunita' di Sant'Egidio hosting four men from the psychiatric ward of the University Hospital Center in Tirana.

The purpose of the Casa Mimosa activities has been since the very beginning to support its guests towards an independent living. So far, two guests of the Casa Mimosa have left the House and have been reintegrated in their family life after a period of restoring daily skills.

Overall need: The number of long-term residents in the 4 hospitals is 466. 58 of those are originally from Elbasan district; 75 are originally from Vlora district, 21 are originally from Shkodra district, and 7 (out of 18 long-term residents in the Tirana psychiatric ward[4]) are originally from the Tirana catchment area of the mini-municipality 5, 6 and 7. Summarising, there are 161 residents that belong to the four priority catchment areas as described above. As stated above, part of the residents will need access to supported accommodation, so a consistent number of places might be required across the country. The rest, after appropriate rehabilitation programs, might either go back to their families or to independent living. In both cases the patients will

[4] Considering the low number of long term patients in Tirana, the objective of the housing activities will be to close the ward

be able to benefit from the needed support from the community mental health services. In order to bring a substantial change in downsizing the number of long-term beds in the psychiatric hospitals, 1-2 protected houses per each catchment area would not only provide decent accommodation to its residents, but would also break the barriers that stigmatise and exclude the mentally ill from the social re-integration.

The number of long-term residents in the 4 hospitals is 466 of which 161 are from the 4 priority catchment areas.

As stated above, the purpose of promoting housing activities is to empower the long term residents of the psychiatric hospital to go on to independent living. That means that for many of the future guests of the housing facilities, the immediate objective of the teamwork there will be to enable them in living a independent and least assisted life as possible. Individual case plans will follow each patient that is transferred from the hospital to the protected housing.

Targets with timeframe: Supported accommodation should be available in the 4 priority catchment areas by December 2006. The number of long-term residents in the 4 hospitals is 466 of which 161 are from the 4 priority catchment areas. An objective for this activity is to have 40-50 protected placements for the mentally ill in the priority catchment areas by the end of December 2006.

The table below describes the activity plan for the supported accommodation for the short- and medium-term period.

Catchment area	Within two years (2005-2007)		Following three years (end of 2009)	
	Number of supported houses	Human resources required	Number of supported houses	Human resources required
Tirana	Two houses	18 staff	One house	9 staff
Shkodra	One house	9 staff	One house	9 staff
Elbasan	Two houses	18 staff	Two houses	18 staff
Vlora	One house	9 staff	Two houses	18 staff
Total	6 houses	54 staff	6 houses	54 staff

Implementation plan: In Elbasan, two supported accommodation activities will be implemented during the next two years. Two other houses are planned to be established in Tirana during the same period. One more house is planned in

Shkodra and another one in Vlora. All facilities shall be offered either by the municipality, by health authorities or by the social welfare system. Staff and other running costs will be covered by MoH. The staff to work in the supported accommodation will come out of the existing resources of the psychiatric hospitals and/or of additional resources from the health, social welfare or municipality's budget. That means that the existing number of human resources of the hospitals will NOT be cut down/ downsized. Their working future lies in the multiple alternatives to the hospital treatment: community mental health centres, supported accommodation, rehabilitation units, etc. Other required resources for the implementation will come from external investments.

The implementation of the housing activities is closely linked to the institutional and individualised case plans (see page 61-62). Not only the shift of the resources from the hospital to the community should be foreseen there, but also plans for daily skills training to those that go into supported accommodation is of crucial importance.

Possible barriers to implementation: Lack of available housing (due to general housing shortage in Albania), lack of staff for supported accommodation.

Indicator(s) for evaluation of activity: Number of supported beds in supported accommodation. Number of mental health staff involved in supported accommodation by type of profession. Percentage of beds used in supported accommodation. Percentage of users gone into independent or less assisted living in a two year period.

Complementary activities to de-institutionalization

4) Income generation activities help re-establish the capacity of the patients to function in the community. This sub-activity (a) increases the capacity of patients to live outside the hospital, (b) decreases disability, (c) facilitates social reintegration, and, as a result, (d) often reduces symptomatology by promoting self-efficacy/citizenship. The activities should provide full-time, part-time and voluntary work placements for (ex-) inpatients to

Income generation activities help re-establish the capacity of the patients to function in the community.

facilitate the transition back into the community.

Current situation: Income generation activities have started to be planned.

A working group in Elbasan has been established to identify potential beneficiaries within the psychiatric hospital, as well as to identify the context of the local situation in terms of employment, job market, etc.

The NGO Alternativa is supporting, with external one time capital investment, an income generating activity, whose beneficiaries are users and ex-users of the psychiatric ward of Tirana.

Overall need: All those patients in the four institutions whose functioning is sufficient to benefit from income generation activities should become involved in such activities.

Targets with timeframe: Patients in the four institutions who are from the four priority catchment areas and whose abilities allow them to benefit from income generation activities should become involved in such activities (by December 2005).

Implementation plan: The income generation activities will take place in and outside hospitals. A local working-group will be established to identify activities that reflect the needs of the local community. The local working groups need to involve not only the direct beneficiaries and the mental health professionals, but also the local health and social authorities, local government, business community, etc. Income-generation activities will be user-led. Support (e.g. on the job training, study visits) will be provided by groups with similar experiences already developed in the country and in the region (FYRO Macedonia, Italy).

The income generation activities might encounter lack of support from the local governments in the respective priority catchment areas.

Possible barriers to implementation: The income generation activities might encounter lack of support from the local governments in the respective priority catchment areas. There is a lack of commitment of the Ministry of Labour and Social Affairs and its line departments in the catchment areas. Stigma and discrimination against the mentally ill that leads to

prejudices about their potentials.

Indicator(s) for evaluation of activity: % of participating inpatients and ex-inpatients who acquire full-time, part-time and voluntary work placements in the community as a result of this sub-activity. % of patients involved in social enterprise discharged from hospital. % of participating ex-patients who become economically self-sufficient.

5) Family activities become important when considering that most of the mentally ill have poor access to specialised services countrywide and the only support they do receive is the family supporting network. Therefore the family members need to be provided skills to live with and help mentally ill relatives. The families would need support (a) to reduce burden of mental illness, (b) to be enabled to cope with the mentally ill relatives, and (c) to be enabled to look for support.

Current situation: Family activities initiatives had a limited impact due to several factors mainly linked to a culture of low citizenship and community participation. However, out of a two years programme of activities with family representatives mainly from the four areas (training, regular meetings, etc), there does exist a registered National Association of Relatives in Mental Health (NARMH), which still needs much capacity building and empowerment.

Overall need: All families who may potentially take care of mentally ill relatives at home should become beneficiaries of such activities.

Targets with timeframe: All families who are from the four priority catchment areas and who may potentially take care of mentally ill relatives at home should become beneficiaries of family activities, (by December 2005).

Implementation Plans: The family activities will go on with a new program of meetings with the NARMH from the 4 priority areas. This program will be developed to empower their role in the system. The program will consist of training, exchange programs with similar experiences in other countries, etc.

The family activities will go on with a new program of meetings with the NARMH from the 4 priority areas. This program will be developed to empower their role in the system.

Possible barriers to implementation: Delays in implementation following a longer process than previously planned of empowerment due to the above mentioned low citizenship and low community participation.

Indicator(s) for evaluation of activity: Number of interventions addressed to families

Activity implementation details					
	Institutional and individualized case plan	Stop admission activities	Housing activities	Family activities	Income generation activities
Responsibility for implementation	The hospitals, MoH, and community mental health teams (in Tirana, Elbasan, Vlora, Shkodra) with advice from WHO (in Tirana, Elbasan) and UNOPS/PASARP (in Vlora, Shkodra).	The hospitals (Tirana, Elbasan, Vlora, Shkodra) with advice from WHO (in Tirana, Elbasan) and UNOPS/PASARP (in Vlora, Shkodra).	The hospitals, MoH, Ministry of Social Affairs (Tirana, Elbasan, Vlora, Shkodra), WHO (in Tirana, Elbasan) and UNOPS/PASARP (in Vlora, Shkodra) Comm. Sant'Egidio.	The hospitals and community mental health teams (Tirana, Elbasan, Vlora, Shkodra), WHO (in Tirana, Elbasan) and UNOPS/PASARP (in Vlora, Shkodra).	The hospitals, community mental health teams and local governments (Tirana, Elbasan, Vlora, Shkodra), WHO (in Tirana, Elbasan) and UNOPS/PASARP (in Vlora, Shkodra)
Estimated Cost 2005-2007	No direct costs from the MoH. Capacity building to the involved staff from external funds.	No direct costs from the MoH (unless some rehabilitation is required). Capacity building to the involved staff from external funds.	75.818.880 Leks, including staff costs, running costs and inpatient costs for six protected houses from the four areas. Capital investments from external funds for restructuring and refurnishing the public facilities; training for involved staff.	No direct costs from the MoH. Capacity building from external funds.	No direct costs from the MoH Capital investments for start up activities and training from external funds.
Other resources required	Local government, Ministry of Labour and Social Affairs, local NGOs will provide resources				
Financing	MoH, WHO, UNOPS/PASARP, and any other interested donors will provide financing.				

1C) CAPACITY BUILDING AND REFRESHER TRAINING OF MENTAL HEALTH PROFESSIONALS

For more effective care, professionals need to upgrade their knowledge (especially with regard to community mental health care) and they should annually receive refresher training.

Purpose and description: For more effective care, professionals (psychiatrists, neuro-psychiatrists working in mental health, nurses working in psychiatric care) need to upgrade their knowledge (especially with regard to community mental health care) and they should annually receive refresher training.

Current situation: The residency for psychiatrists presently lasts four years, but this is only so recently due to a regulation made and applied by the Faculty of Medicine during the last decade. The majority of the psychiatrists working in the hospitals were trained earlier and have received only a 1-year residency course, which took place before the last decade. Most mental health professionals that work in the public structures in the districts have received insufficient training.

A particular problem is that there is no special training or education course for psychiatric nursing (neither at the graduate nor at the undergraduate level). Another problem is the lack of young trained mental health professionals to work in the mental health services outside Tirana. Therefore, the Ministry of Health should find flexible solution to informally train the existing health resources of the rest of the country in order to minimally ensure some kind of mental health expertise in the areas where this is not at all available.

With respect to the priority catchment areas, the table below presents an overview of the existing psychiatrists and nurses currently working in the psychiatric services.

	Number of Psychiatrists	Number of nurses
Tirana	35	76
Shkodra	3	21
Elbasan	8	51
Vlora	6	35

Overall need: Throughout the country, all psychiatrists, neuro-psychiatrists and nurses working in mental health should receive a minimal of 10 days of training per year in community mental health. In addition, ongoing supervision is necessary.

Targets with timeframe:

	Content	Psychiatrists and Neuro-psychia--trists working in mental health	Nurses working in mental health
4 areas (+ possibly peripheral areas when relevant)	Capacity building + refresher training	10 days / year	10 days / year
Remainder of country	Refresher training	2 days / year	2 days / year

Implementation plan: Local trainers (university, WHO). University will develop curricula with support from the WHO Albania. There will be a Training of Trainers for 50 nurses in mental health nursing organized by WHO through the Nursing School in Tirana.

Possible barriers to implementation: None

Indicator(s) for evaluation of activity: Numbers of people trained (quantitative evaluation), feedback through focus groups with trainees (qualitative evaluation).

Activity implementation details	
Responsibility for implementation	Ministry of Health, University and WHO
Estimated Cost 2005-2007	1.000.000 Leks for the 4 priority catchment areas. 400.000 Leks for the remainder of country (8 prefectures), from the MoH. Training for the involved staff (study visits, on the job training), from external funds.
Other resources required	Teaching facilities, MoH permission to teach its staff and allowances for the training period, university trainers and WHO
Financing	MoH,University, WHO, UNOPS/PASARP

1D) REVISION OF THE MENTAL HEALTH ACT

Purpose and description: The national mental health legislation is from 1996 and requires (a) revision, (b) elaboration of normative acts and (c) awareness among key stakeholders.

Revision and procedures for implementation are needed in particular for:

1. Definition by the Ministry of Health and Ministry of Social Affairs of the rehabilitation policy in the psychiatric institutions. (article 18)
2. Elaboration of the regulations on physical restraints, immobilisation, or isolation and the relation with the police. (article 24)
3. Definition of the procedures and the commission responsible for the physical restraint decision (regulation) Article 23
4. Amendment of the request for the identification of the Legal Tutor towards a realistic solution (article 28)
5. Definition of the procedures (regulations) in relation with the court (article 28)
6. Elaboration of the regulation on the types of therapy medications that require the patient's or the Legal Tutor's approval (Article 33)
7. Elaboration of the procedures (regulation) by the Ministry of Justice and the Ministry of Health, applicable in forensic psychiatry. (Article 42)

Current situation: The Albanian Parliament approved the Mental Health Act in Albania in 1996. At that time, this was a step forward in institutional awareness of the human rights of the mentally ill. Meanwhile Albania has rapidly gained insight on the importance of human rights issues in general. The present Act has not yet been implemented. The human rights of the mentally ill continue to be violated at two levels:

a) The psychiatric institutions do not fully apply appropriate admission procedures and treatment options in legal terms because of the non-existence of normative acts in support to the Mental Health Act 1996. The living situation of the mentally ill as well as the lack of alternative accommodation facilities for those that do not need hospitalisation, creates

The national mental health legislation is from 1996 and requires revision, elaboration of normative acts and awareness among key stakeholders.

the ground for violation of their human rights.

b) Outside the psychiatric institutions, rights are violated in prisons but also through poor access to services and non-availability of basic reimbursable care (incl. medication).

A major concern is also the frame for the treatment of mentally ill law offenders. Not only the procedures for their case management needs revision, but especially the accountability of the health and judicial institutions need clarification. At present the government has undertaken the task to formulate and implement a proper solution for mentally ill law offenders.

During 2003, in the frame of the SEE Stability Pact Mental Health Project and supported by WHO, a process of reviewing existing legislation with regard to mental health took place. A package of laws that consists of a comprehensive review of the existing Legislation with regard to mental health issues was presented to a large group of representatives of services, service users and other relevant stakeholders. Consultations were held in order to raise awareness about the need to increase the implementation of the mental health legislation.

Overall need: The Act needs to be reviewed and implemented.
It needs updating in the near future, along the lines set out in the WHO book (2005). Urgent action is needed to produce the necessary regulations and clarifications required in the law.

Targets with timeframe:

(a) Identification of gaps that prevent the implementation of the Act (by June 2005)
(b) Elaboration of normative acts (by June 2005)
(c) Training for main stakeholders (by June 2005)
(d) Forensic mental health service delineated (by June 2005)

Implementation plan: A working group will be responsible for (a) and (b). Potential members are: A representative of the legal unit of MoH (chairperson), a judge, a law professor, a representative of ombudsman office, a representative of the university clinic, a representative of the psychiatric hospital, a representative of a family association, and an Albanian

A working group will be responsible for the identification of gaps that prevent the implementation of the Act and elaboration of normative acts

representative of WHO. With respect to awareness raising, WHO will promote the development of the main stakeholders training.

With respect to (d) the delineation of the forensic mental health service, an inter ministerial working group, mandated by the Prime Minister will formulate the final solution. Technical expertise by WHO will continue to be provided.
However, the mental health teams from each one of the priority catchment areas, with the technical support of the respective international agencies, will assess the forensic populations of their areas, in order to understand how many forensic cases are in each of the areas, what happens to them, which one of the institution is currently in charge of, etc.

Furthermore, the Directory of Legal Affairs at the MoH will prepare the necessary papers to initiate the revision of the Mental Health Act at the Parliament level.

Possible barrier to implementation: Working group meetings may not be regularly called.

Indicator(s) for evaluation of activity: Existence of document with procedures for implementation. Numbers of people trained (quantitative evaluation). Feedback through interviews with stakeholder trainees (qualitative evaluation).

Activity implementation details	
Responsibility for implementation	The implementation is under full responsibility of the Ministry of Health that should tutor the above. WHO, in coordination with the National Steering Committee, will initiate the creation of and will technically support the working group.
Estimated Cost 2005-2007	No direct costs from the MoH. External consultancies from external funds.
Other resources required	Inputs of stakeholders
Financing	WHO for the technical support to the forensic mental health services staff, other potential donors

2. SHORT-TERM ACTIVITIES (2 YEARS)

2A) DEVELOPMENT OF COMMUNITY MENTAL HEALTH SERVICES FOR BOTH INPATIENTS AND OUTPATIENTS

Purpose and description: See Policy document for purpose and description of this activity. The activity involves restructuring existing psychiatric ambulatory services. This includes both acute inpatient care and day centres and follow-up visits in the community, etc. In the day centres, relatives could help staff during the day for certain activities, organization and maintenance issues.

The community mental health service will consist of:
- A community mental health centre (including a day centre)
- Acute and medium-term inpatient care (which may be at the general hospital or at the community mental health centre)
- Supported accommodation (see activity 1b)

Please see the organogram page 90, for an overview of the configuration of the community mental health service

Current situation: The community mental health centre (CMHC) of Tirana is working under full financial coverage (staff costs and running costs) of the Regional Health Authority. Most of the centre's staff has had on-the-job training in Birmingham, UK. Nursing staff are receiving further training from UK professionals.

The centre's staff in collaboration with the staff of the psychiatric ward of Tirana and supervised by the WHO Mental Health team in Albania, recently conducted a survey about the total number of admissions of the population of Tirana (352,581 inhabitants) for a 12 months period July 2003 - July 2004. The survey focused on two separated catchment areas: one is the catchment area of the population (111.062 inhabitants) served by the Community Mental Health Center and its multi-

The activity involves restructuring existing psychiatric ambulatory services, acute inpatient care and day centres and follow-up visits in the community

disciplinary team of 11 mental health professionals and the other is the catchment area of the population (241,419 inhabitants) served by two traditional outpatient psychiatric teams composed altogether of 4 psychiatrists and 4 nurses. The findings show a substantial difference between the number of 45 hospital admissions for the population served by the multi-disciplinary team of the CMHC and the number of 576 hospital admissions for the population served by the two traditional outpatient psychiatric teams.

The hospital admission rate for the community center catchment area is 0.4 per 1000 population while it is 2.4 per 1000 population for the catchment area served by traditional outpatient services. That is, the hospital admission rate for the traditional system is 6 times that of the community center catchment area.

In Elbasan, a community mental health centre is functioning in the polyclinic, with staff and running costs covered by MoH. A building close to the psychiatric hospital was renovated and furnished and is functioning as rehabilitation unit. 45 long-term residents of the psychiatric hospital of Elbasan are benefiting from the activities of the rehabilitation unit and are supported in improving their daily skills as a way towards social re-integration.

Both Elbasan teams (from the community mental health centre and the hospital) have received on-the-job-training locally and abroad through an exchange program with Plymouth and Monaghan Mental Health Services.

Across the country there are 33 outpatient units in polyclinics or general hospitals that deliver services for adults and one for children and adolescents.

The Pilot Admission Service in Vlora is working on reducing the number of admissions through adopting admission criteria that prevent the inappropriate admissions for the Vlora catchment area. The population of the Vlora catchment area (147.128 inhabitants) receives comprehensive services through a mobile team that provides home care, rehabilitation of daily skills, etc. The rest of the hospital's catchment area (about 590.000 inhabitants) receives traditional outpatient service by small psychiatric teams composed by one psychiatrist and one nurse. The current findings reported by the hospital's management for

the period December 2003-October 2004, show that out of 411 requests for admission in the Vlora psychiatric hospital, only 11 out of 144 (7,6%) of requests from the Vlora catchment area were transferred to the wards, while 93 out of 267 (34,8%) of requests from the rest of the catchment area were transferred in the wards.

In many areas of the country (but not in each catchment area), there are so-called neuro-psychiatric cabinets (consisting of a doctor and a nurse) who function as subunits in polyclinics, which provide outpatient care. The doctors in these cabinets are sometimes neurologists or neuro-psychiatrists but typically have insufficient training, and none of nurses have received formal training in psychiatry. Across the country there are 33 outpatient units in polyclinics or general hospitals that deliver services for adults and one for children and adolescents. There is one neuropsychiatric ward in the Military Hospital, there are 8 private outpatient clinics and one Child Development Center. In total, there are 42 outpatient facilities for adults and two for children and adolescents' mental health. These facilities are staffed by 40 neuro-psychiatrists and psychiatrists (13 psychiatrists + 27 neuro-psychiatrists).

The services that do currently exist for children and adolescents' mental health are concentrated in Tirana. They do provide care by multi-disciplinary teams and mostly due to the fact that they are accountable to different authorities within the MoH system, their work remains conveyed fragmentarily to the due supervisors.

A major constraint in this area is the low motivation of health professionals to work in mental health settings. As a consequence of stigma and prejudices against mental illnesses and the mentally ill, the new generations of health professionals prefer to remain jobless rather than work with the mentally ill. Most of the mental health services countrywide are staffed with professionals that soon will go into retirement. Furthermore there is no incentive policy that might increase motivation of potential staff to work outside Tirana, thus the mental health services outside Tirana are understaffed both in quantity and quality terms.

Overall need: Transformation of existing services into fully developed community mental health teams/services. A government directive is needed to formally allow acute psychiatric inpatient care in general hospitals. A government decision is needed to incentivate the mental health workers in order to increase their motivation to work in the services. A MoH action is needed to integrate the work of the children and adolescents mental health care under one technical supervising agency, thus promoting one network of specialised services for children and adolescents.

Targets with timeframe: Development of community mental health teams/services throughout the country. However, resources have thus far only been raised for the 4 priority catchment areas (implementation before June 2006). A government directive is needed to formally allow acute psychiatric inpatient care in general hospitals (by June 2005). A government decision is needed to allow financial incentives for mental health workers (by December 2005)

Implementation plan:
4 priority catchment areas: Ministry of Health is already implementing community based mental health activities supported by WHO in Tirana and Elbasan, and supported by UNOPS/PASARP in Shkodra and Vlora. One community mental health service is being established in Vlora under support from the SEE Stability Pact Mental Health Project and technically supervised by WHO.

Remainder of country: To be developed for the medium-term.

Government Directive: A government directive is needed to transform the nominative standards for the existing psychiatric cabinets. One suggestion is to transform the psychiatric cabinets automatically into community mental health centres with the required staff and respective job description. The directive would be issued by the human resources department in the MoH.

Possible barriers to implementation:
4 priority catchment areas: lack of facilities, lack of flexibility in shifting resources across sectors, lack of incentives.

A major constraint in this area is the low motivation of the health professionals to work in mental health settings.

Remainder of country: lack of facilities, lack of flexibility in shifting resources across sectors, lack of motivated human resources, lack of financing, and lack of incentives.

Indicator(s) for evaluation of activity: Percentage of re-admissions to mental hospital within 30-days of discharge and within 1-year of discharge. Number of community contacts provided by community mental health teams.

Activity implementation details	
Responsibility for implementation	MoH in collaboration with WHO in two areas (Tirana and Elbasan), MoH in collaboration with UNOPS/PASARP in two other areas (Vlora and Shkodra). Other areas that might become priority at a later stage under the MoH full responsibility (technical and financial)
Estimated Cost 2005-2007	118.800.000 Leks (one inpatient and one outpatient facility for each one of the respective catchment areas[5]), from the MoH. Capacity building to the involved staff, from external funds.
Other resources required	
Financing	WHO (2 areas), UNOPS/PASARP (2 areas), SEE Stability Pact Mental Health Project (1 area), in collaboration with MoH

2B) TRAINING OF PRIMARY CARE WORKERS

Purpose and description:

Purpose of mental health care in PHC: The purpose of training primary care workers is to identify patients with mental disorders, to treat patients with common mental disorders and to refer patients with complex, severe mental disorders. Of note, the vision is that trained PHC doctor will receive supervision from the community mental health team through organized case discussions. The consolidation of the referral system will allow the early detection of mental disorders, thus increasing prevention, and will also increase the outcomes of the follow up of individual cases by mutual communication between the GP and the specialised service, thus improving the prevention of relapses.

[5] See the report from the health economist. The estimation includes staff and running costs for all the facilities.

Description of refresher training: Training presently lasts 2 days (but the length of the training may be increased). Each training will involve approximately 10 trainees and 2 trainers.

Government directive: A MoH directive is needed to formally allow PHC workers to treat mental disorders and to formalize the referral system between PHC and mental health service.

Current situation:

University training: The studentship for future physicians (a six years course) includes a three weeks internship in general psychiatry (2.4 % of the total medical curriculum) in the Psychiatric ward of the Tirana University Hospital Centre as well as the same number of hours in Medical Psychology. Three out of 88 weeks (3.4%) is spent by GPs in psychiatry during GPs postgraduate training. Existing curricula need to be revised. Undergraduate training for general nurses includes 64 academic hours in mental health out of a total of 3245 academic hours during undergraduate training. In other words 2% of hours of general nursing training cover mental health. Important changes have been made to the curricula of students paying more attention to community mental health system of care. Nevertheless, the existing curricula need to pay more attention to psychiatry and mental health, offering more inputs on community mental health care.

Refresher training. Refresher training started in the fall of 2003. In 2003, across Albania, 87 out of 1597 GPs (5%) and 225 out of 6596 PHC nurses (3%) received at least 2-days in-service refresher training in mental health.

The purpose of training primary care workers is to identify patients with mental disorders, to treat patients with common mental disorders and to refer patients with complex, severe mental disorders.

Presence of recognized treatment protocols in PHC. There is a recent publication of treatment protocols for the PHC supported by the HII.

Government directive: PHC workers are allowed to prescribe psychotropic drugs under recommendations delivered by psychiatrists.

Overall need

University training: Existing curricula needs to be extended even more in topics related to community mental health system of care.

Refresher training. Across Albania, all GPs and nurses need to receive annually at least 2-days in-service refresher training in mental health as/with supervision sessions from the community mental health services. Existing training package need to be revised.

Targets with timeframe:
University training: Existing curricula need to be revised and implemented (by academic year starting Sep 2005).

Refresher training. In the 4 priority catchment areas, 36% of GPs and 17% of nurses will be trained in Year 1 and 100% of GPs and 100% of nurses will be trained in Year 2. The above division considers the respective figures on the city and the rural health workforce of the four priority areas.

Implementation plan:
University training: A Conference with participation of foreign experts and representatives of interested Departments of school of Medicine, School of Nursing, in the Spring of 2005 resulting in recommendations for appropriate improvements in different curricula and the CME system, involving Ministry of Education and Science, Institute of Public Health.

Drafts of revised Programs by School of Medicine Departments and School of Nursing by July 2005.

Approval from the Dean of School of Medicine by September 2005.

Refresher training. MoH and the Department of Psychiatry (Faculty of Medicine), supported by WHO will prepare until Spring 2005 the curricula of the training.

MoH will prepare the directives and plan the participation schedule of GPs and nurses by Spring 2005 as well as modalities of every training session, (e.g. describing the number of trainers, training methodology, etc)

Possible barriers to implementation:
University training: Lack of resources in the university.

Existing curricula needs to be extended even more in topics related to community mental health system of care.

Refresher training. None

Indicator(s) for evaluation of activity:
Overall: Number of patients identified, number of patients referred and number of patients treated in PHC - all within a 1 year period.

University training: New curriculum is implemented in the university.

Refresher training. % of doctors and nurses who annually received at least 2-days of training.

Activity implementation details	
Responsibility for implementation	The university (for university training and treatment protocols), University and MoH (for refresher training)
Estimated Cost 2005-2007	1.600.000 Leks for the four priority catchment areas, from the MoH. Training modules from external funds.
Other resources required	Teaching facilities, MoH permission to teach its staff and allowances for the training period, MoH and university trainers, WHO technical assistance
Financing	The university + MoH + WHO (university training, refresher training and treatment protocols), other possible donors for the curricula and CME conference.

2C) MONITORING SYSTEM OF OVERALL SERVICES AND INDIVIDUAL CARE

Purpose and description:
System and service-level monitoring: to facilitate planning and accountability.

Patient-level monitoring: to ensure continuity of care.

Current situation: No systematic monitoring on national level. Initiatives on monitoring are being performed locally in Vlora, Elbasan, Tirana and Shkodra. There are annual findings reported internally to the hospitals management, but due to the lack of a national mental health monitoring tool, the findings that are reported in the Ministry of Health are fragmented. The data reported are mostly based on the existing patient chart that is far from being complete and does not reflect the complexity of the needs of the mentally ill. Initiatives on improving the patient chart have been taken by the services in Tirana, Elbasan and Vlora, but those still need to be integrated and standardised in the MoH monitoring system.

Overall need
system and service-level monitoring A basic monitoring system overseen by the proposed Mental Health Sector (see activity 1a). i.e. the monitoring would be done by one of the 2 people in the Mental Health Sector.

patient-level monitoring: A basic patient chart integrated in the health monitoring system.

Target with timeframe: To have the monitoring in place (by June 2005)

Implementation plan: the following steps will be undertaken using the existing local experiences and initiatives in this area:
- Definition of mental health monitoring tools to monitor overall services (eg simplification of the new WHO tool) by WHO and or its consultants in collaboration with the university
- Definition of mental health information system to monitor

The data reported are mostly based on the existing patient chart that is far from being complete and does not reflect the complexity of the needs of the mentally ill.

ongoing care of each patient.
- Dissemination and integration at the central and field level.
- Exploration of the use of new technologies and web-based systems on a pilot or demonstration basis for the implementation of these tools and mechanisms.

Possible barriers to implementation: None

Indicator(s) for evaluation of activity
system and service-level monitoring: Presence of the monitoring system of mental health services in place and integrated into the MoH national health monitor.

patient-level monitoring: presence of a basic comprehensive patient chart applicable in at least the four priority catchment areas and integrated into the national health monitor data collection.

Activity implementation details	
Responsibility for implementation	WHO (drafting), University, MoH (review and implementation)
Estimated Cost	Cost covered under activity 1a, from the MoH. Capacity building (definition and implementation of monitoring tools) from external funds.
Other resources required	University + MoH time to review draft. MoH to continuously provide forms, and collect, analyze and report on data. Cost of implementation by Mental Health Sector is covered under activity 1a
Financing	WHO (piloting patient chart), MoH (development costs)

2D) ELABORATION OF AN ACTIVITY PLAN TO PROMOTE MENTAL HEALTH

Purpose and description: Promote mental health for all, working with individuals and communities; combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Current situation: No national program. There are a number of governmental and non-governmental organizations undertaking non-coordinated programs. No public budget allocated to mental health promotion.

Overall need

- Actions across whole population to strengthen individuals to enhance their psychological well-being, communities in tackling local factors which determine mental health.
- Anti-stigma programmes
- National Promotion Campaign

Target with timeframe: The community at large, health workers, individuals at risk, vulnerable groups. National Anti-stigma programme designed and implementation started (by June 2005)

Implementation plan:

- MoH allocates budget for the program.
- MoH opens a call for proposals from public institutions, mental health professionals' organizations, non-profit organizations for projects aiming to combat discrimination against individuals and groups with mental health problems, and to promote their social inclusion.
- Implementation of the selected project(s).

Possible barriers to implementation: No budget allocated.

Indicator(s) for evaluation of activity:

- The % of Mental Health budget allocated for promotion activities
- MoH Mental Health Sector design and implement the procedures for receiving applications

MoH opens a call for proposals from public institutions, mental health professionals' organizations, non-profit organizations for projects aiming to combat discrimination against individuals and groups with mental health problems, and to promote their social inclusion.

- Project(s) selected through pre-established criteria
- Project(s) implemented as previously planned. Ad hoc evaluation of project activities: satisfactory.

Activity implementation details	
Responsibility for implementation	MoH
Estimated Cost	To be defined by the MoH
Other resources required	National Center for Health Promotion/Institute of Public Health
Financing	MoH, NGOs, potential donors

3A) RE-ADMINISTRATION OF RELEVANT PARTS OF MONITORING INSTRUMENT TO ASSESS PROGRESS IN LIGHT OF FURTHER OPERATIONAL PLANNING.

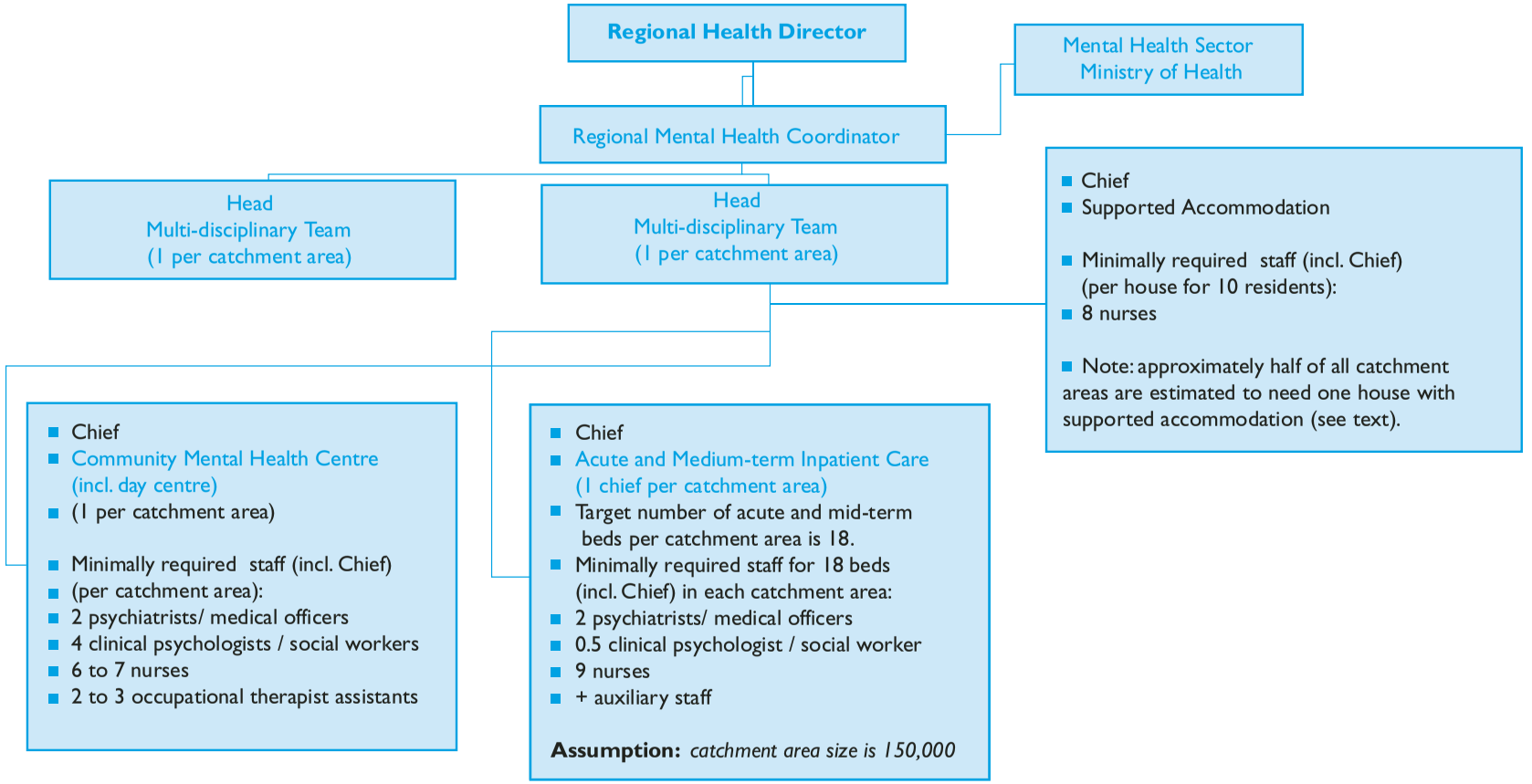
3B) CONTINUATION OF THOSE EMERGENCY/ IMMEDIATE AND SHORT-TERM ACTIVITIES FOR WHICH THE OVERALL NEED HAS NOT YET BEEN MET.

3C) STRENGTHEN FAMILY AND USERS ORGANIZATIONS - CONTINUATION.

3D) INTEGRATING THE CONTINUOUS MENTAL HEALTH EDUCATION INTO THE NATIONAL CONTINUOUS MEDICAL EDUCATION SYSTEM.

3E) ACTIVATING OF RESEARCH BY THE MINISTRY OF HEALTH, FACULTY OF MEDICINE AND OTHER INSTITUTIONS.

Detailed operational planning of these activities will occur by June 2006.



Notes:

- *Assumption:* catchment area size is 150,000 (numbers will need to be adjusted when the catchment size is different.
- The proposed MoH Mental Health Sector (with advice from the National Steering Committee) is responsible for overall technical supervision.
- Inpatient care may take place either at general hospitals or at community mental health centre. If inpatient care takes place at the community mental health centres, the minimal numbers of staff at the community mental health centre would be 4 psychiatrists/medical officers, 4.5 clinical psychologists/social workers, 15-16 nurses, and 2-3 occupational therapist assistants as well as auxiliary staff.
- These minimal resource requirements were calculated informed by example calculations in WHO (2003). Planning and Budgeting to Deliver Services for Mental Health. WHO: Geneva.

All services are in collaboration with:

- General (physical) hospital medicine
- Primary health care services
- Social Affairs Ministry (housing, income generation)
- NGOs (eg existing NGOs for specific problems/populations; family and users associations; income generation activity NGOs)
- Police and prison services
- Relevant professionals in school system
- Private practitioners
- Informal caregivers (eg clerics, family members)

FIGURE. CONFIGURATION OF MENTAL HEALTH SERVICES AT THE REGIONAL AND CATCHMENT AREA LEVEL

Activities and costs for the period 2005 - 2007[6]			
Activity	Estimated Cost from the MoH	Estimated Costs from External Funds	Partners
Emergency/ immediate			
a) Establishment of a technical Mental Health Sector within the Ministry of Health (MoH).	1.260.000 Leks	Capital start-up costs	WHO
b) Discharge of long-term patients into community care (deinstitutionalization).			
- Institutional and individualized case plan	No direct costs	Capacity building to the involved staff	WHO, UNOPS/ PASARP, Sant' Egidio
- Stop admission activities	No direct costs	Capacity building to the involved staff	
- Income generation activities	No direct costs	Capacity building to the involved staff	
- Family activities	No direct costs	Capacity building	
- Housing activities	75.818.880 Leks	Capital investments for restructuring and refurnishing the public facilities; training for involved staff	
c) Capacity building and refresher training of mental health professionals	1.400.000 Leks	Training for the involved staff (study visits, on the job training)	University, WHO, UNOPS/PASARP
d) Revision of the Mental Health Act	No direct costs	External consultancies	WHO
Short-term			
a) Development of community mental health services for both inpatients and outpatients	118.800.000 Leks	Capacity building to the involved staff	WHO, UNOPS/PASARP
b) Training of primary care workers (PHC)	1.600.000 Leks	Training modules	The university + WHO, other donors.
c) Monitoring system of overall services and individual care	Cost covered under activity 1a	Capacity building (definition and implementation of monitoring tools)	WHO
d) Elaboration of an activity plan to promote mental health	To be defined		

[6] The table does not refer to the costs of a system of mental health services country wide. It is related only to the costs of activities described in the present document. Other costs, i.e. existing psychiatric hospitals and wards, psychotropic drugs consumption expenditures, etc. are not included here.